

MARYLAND

STATE DEPARTMENT OF HEALTH

4190

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS SACKED HEART HOSPITAL		STREET ADDRESS (If rural, give location) 10 Massachusetts Avenue	
3. NAME OF DECEASED (Type or Print)	(First) Sadie (Middle) (Last) Bealky	4. DATE OF DEATH (Month) 5 (Day) 6 (Year) 1955	
5. SEX F	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH April 16 1876
9. AGE last birthday 79 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own house	
11. BIRTHPLACE (State or foreign country) Garrett Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Christner		14. MOTHER'S MAIDEN NAME Susan Ringer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Eugene Bittner, Cumberland, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
4201 Immediate cause (a).....		Coronary Thrombosis	6 hrs
Antecedent cause(s)		Cerebral Arteriosclerosis,	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		Chronic Hypertension	?
11. OTHER SIGNIFICANT CONDITIONS		Chronic Bronchitis & Psychotic Reaction	21 mo.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 7, 1953** to **May 6, 1955** that I last saw the deceased alive on **May 6, 1955** and that death occurred at **230 P** m., from the causes and on the date stated above.

SIGNATURE **James B. McLean, M.D.** (Degree or title) ADDRESS **49 Spruce** DATE SIGNED **5-7-55**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE **May 9 1955** NAME OF CEMETERY OR CREMATORY **Hillcrest Burial Park** LOCATION (City, town, or county) (State) **Cumberland, Md.**

DATE REC'D BY LOCAL REG. **May 9, 1955** REGISTRAR'S SIGNATURE **Walter R. Kautz, M.D.** 24. FUNERAL DIRECTOR **William H. Kight** ADDRESS **Cumberland, Md.**

BUREAU V. S.

MAY 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04181

4248 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) Barton		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Lonaconing		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Henry (Middle) Thomas (Last) Beeman				(Month) May (Day) 7 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 13, 1869	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Beeman				14. MOTHER'S MAIDEN NAME Kenzie Ross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Albertus Beeman (SON)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) Coronary Occlusion				Lonaconing, Md.		10 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease						6-7 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 52 , to July , 19 55 , that I last saw the deceased alive on 7 May , 19 55 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
SIGNATURE George Richards		M.D.		ADDRESS (Street, city, town, state) Lonaconing Ind		DATE SIGNED 5-8-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF May 9, 1955		NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		LOCATION (City, town, or county) (State) Moscow, Md.	
24. REC'D BY REGISTRAR May 9, 1955		REGISTRAR'S SIGNATURE Mr. Geo. C. Kelly		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		ADDRESS	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED: Henry Thomas

RESIDENCE: Baltimore, Md.

AGE: 45 years

SEX: Male

DATE OF DEATH: April 12, 1968

PLACE OF DEATH: Home

Cause of Death: Myocardial Infarction

Immediate Cause: Coronary Atherosclerosis

Underlying Cause: Hypertension

Contributing Cause: Smoking

BUREAU V. 1

MAY 11 1968

RECEIVED

May 8, 1968

George Johnson, Registrar

4191

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
CITY OR TOWN <u>Booths & Cumberland</u>		LENGTH OF STAY (In this place) <u>35 Yrs</u>		CITY OR TOWN <u>Booths & Cumberland</u>		CITY OR TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt I Cumberland</u>				STREET ADDRESS (If rural give location) <u>Rt. I Cumberland</u>			
3. NAME OF DECEASED (Type or Print) <u>Frank</u> (First) <u>Boch</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>May</u> <u>6</u> <u>1955</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/19/1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C&W Electric Railway</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Mary Boch Rt I Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						7 Days	
334X IMMEDIATE CAUSE (A) <u>Cerebral Apoplexy</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2, 1955</u> to <u>May 6, 1955</u> , that I last saw the deceased alive on <u>May 6, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. M. Weeks</u>				ADDRESS (Street, city, town, state) <u>49 Green St</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>May 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Winters R. L. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. Dist. No.

A. Name of deceased (Print or type)

1. Name of deceased (Print or type)
2. Date of birth (Print or type)
3. Sex (Print or type)
4. Race (Print or type)
5. Marital status (Print or type)
6. Occupation (Print or type)
7. Usual residence (Print or type)
8. Date of death (Print or type)
9. Place of death (Print or type)
10. Cause of death (Print or type)
11. Medical certificate (Print or type)
12. Signature of physician (Print or type)
13. Signature of registrar (Print or type)
14. Signature of informant (Print or type)
15. Date of registration (Print or type)

1. Name of deceased (Print or type)

2. Date of birth (Print or type)

3. Sex (Print or type)

4. Race (Print or type)

5. Marital status (Print or type)

6. Occupation (Print or type)

7. Usual residence (Print or type)

8. Date of death (Print or type)

9. Place of death (Print or type)

10. Cause of death (Print or type)

11. Medical certificate (Print or type)

12. Signature of physician (Print or type)

13. Signature of registrar (Print or type)

14. Signature of informant (Print or type)

15. Date of registration (Print or type)

16. Name of informant (Print or type)

17. Address of informant (Print or type)

18. Date of completion (Print or type)

19. Signature of registrar (Print or type)

20. Date of registration (Print or type)

21. Signature of informant (Print or type)

22. Date of registration (Print or type)

BUREAU V. S.

MAY 16 1955

RECEIVED

EXHIBIT

THIS CERTIFICATE IS A SUMMARY OF THE INFORMATION CONTAINED IN THE DEATH RECORD AND IS NOT A SUBSTITUTE FOR THE ORIGINAL RECORD. IT IS SUBJECT TO THE SAME LAWS AND REGULATIONS AS THE ORIGINAL RECORD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

DR. W. F. WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04183

Reg. Dist. No. 4

4132

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		19 HRS.		TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
60 MEMORIAL AVE HOSPITAL				307 HELEN ST.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
MR. LLOYD L. BUCY				MAY 19 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	NOV. 25 1895	59 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Mail Carrier		Post Office		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DNETON BUCY				MARY HUFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
Yes 1st World War				None		MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3	
570.5 IMMEDIATE CAUSE (A) Cardiac failure from							
DUE TO ANTECEDENT CAUSE(S) (B) intestinal obstruction						days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> el work Not while <input type="checkbox"/> el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5:18, 1955, to 3:19, 1955, that I last saw the deceased alive on 5:19, 1955, and that death occurred at 12:00 P.M. from the causes and on the date stated above.							
SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city, town, state) Cumberland		DATE SIGNED 5-19-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 22 1955		Greenmount Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
May 19, 1955		Winter R. Tandy M.D.		H. H. Knight		Cumberland, Md.	

CERTIFICATE OF DEATH

6193

1. NAME OF DECEASED JOHN H. HENRY		2. SEX MALE	
3. AGE 45		4. RACE WHITE	
5. DATE OF DEATH MAY 24 1955		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH HOSPITAL		8. CAUSE OF DEATH HEART DISEASE	
9. MANNER OF DEATH NATURAL		10. SIGNATURE OF PHYSICIAN J. H. HENRY	
11. SIGNATURE OF REGISTRAR J. H. HENRY		12. SIGNATURE OF WITNESSES J. H. HENRY	

BUREAU V. S.

MAY 24 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04184

4237

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1. Frostburg</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner's Hope</u>				STREET ADDRESS (If rural give location) <u>Y</u>			
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>Buskirk</u> (Middle) <u>Buskirk</u> (Last)				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1913</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Midland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Buskirk</u>				14. MOTHER'S MAIDEN NAME <u>Janet Klum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-09-7343</u>		17. INFORMANT & ADDRESS <u>Sister Mrs. Paul Aldridge. Woodland, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>050X</u> IMMEDIATE CAUSE (A) <u>Scarlet Fever</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/13/1955</u> to <u>5/16/1955</u> that I last saw the deceased alive on <u>5/16</u> 19 <u>55</u> and that death occurred at <u>10:34</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>C. W. E. Gattens</u>		M.D. <u>11678 Minn</u>		ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>5/16/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) <u>Frostburg, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Nancy V. Rose</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, Md.</u>	
DATE <u>5-18-55</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE OF DECEASED

MARYLAND

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. SEX OF DECEASED

8. AGE OF DECEASED

9. OCCUPATION OF DECEASED

10. MARITAL STATUS OF DECEASED

11. EDUCATION OF DECEASED

12. RELIGION OF DECEASED

13. RACE OF DECEASED

14. COLOR OF DECEASED

15. HEIGHT OF DECEASED

16. WEIGHT OF DECEASED

17. TEMPERATURE OF DECEASED

18. PULSE OF DECEASED

19. RESPIRATION OF DECEASED

20. BLOOD PRESSURE OF DECEASED

21. URINE OF DECEASED

22. STOOL OF DECEASED

23. SWEAT OF DECEASED

24. SALIVA OF DECEASED

25. TISSUES OF DECEASED

26. SKIN OF DECEASED

27. HAIR OF DECEASED

28. NAILS OF DECEASED

29. TEETH OF DECEASED

30. EYES OF DECEASED

31. EARS OF DECEASED

32. NOSE OF DECEASED

33. MOUTH OF DECEASED

34. THROAT OF DECEASED

35. LARYNX OF DECEASED

36. TRACHEA OF DECEASED

37. BRONCHI OF DECEASED

38. LUNGS OF DECEASED

39. HEART OF DECEASED

40. LIVER OF DECEASED

41. SPLEEN OF DECEASED

42. PANCREAS OF DECEASED

43. GALLBLADDER OF DECEASED

44. STOMACH OF DECEASED

45. SMALL INTESTINE OF DECEASED

46. LARGE INTESTINE OF DECEASED

47. RECTUM OF DECEASED

48. VAGINA OF DECEASED

49. UTERUS OF DECEASED

50. OVARY OF DECEASED

51. TESTIS OF DECEASED

52. PROSTATE OF DECEASED

53. BLADDER OF DECEASED

54. URETER OF DECEASED

55. PENIS OF DECEASED

56. CLITORIS OF DECEASED

57. VULVA OF DECEASED

58. PERINEUM OF DECEASED

59. ANUS OF DECEASED

60. SKIN OF DECEASED

61. HAIR OF DECEASED

62. NAILS OF DECEASED

63. TEETH OF DECEASED

64. EYES OF DECEASED

65. EARS OF DECEASED

66. NOSE OF DECEASED

67. MOUTH OF DECEASED

68. THROAT OF DECEASED

69. LARYNX OF DECEASED

70. TRACHEA OF DECEASED

71. BRONCHI OF DECEASED

72. LUNGS OF DECEASED

73. HEART OF DECEASED

74. LIVER OF DECEASED

75. SPLEEN OF DECEASED

76. PANCREAS OF DECEASED

77. GALLBLADDER OF DECEASED

78. STOMACH OF DECEASED

79. SMALL INTESTINE OF DECEASED

80. LARGE INTESTINE OF DECEASED

81. RECTUM OF DECEASED

82. VAGINA OF DECEASED

83. UTERUS OF DECEASED

84. OVARY OF DECEASED

85. TESTIS OF DECEASED

86. PROSTATE OF DECEASED

87. BLADDER OF DECEASED

88. URETER OF DECEASED

89. PENIS OF DECEASED

90. CLITORIS OF DECEASED

91. VULVA OF DECEASED

92. PERINEUM OF DECEASED

93. ANUS OF DECEASED

94. SKIN OF DECEASED

95. HAIR OF DECEASED

96. NAILS OF DECEASED

97. TEETH OF DECEASED

98. EYES OF DECEASED

99. EARS OF DECEASED

100. NOSE OF DECEASED

101. MOUTH OF DECEASED

102. THROAT OF DECEASED

103. LARYNX OF DECEASED

104. TRACHEA OF DECEASED

105. BRONCHI OF DECEASED

106. LUNGS OF DECEASED

107. HEART OF DECEASED

108. LIVER OF DECEASED

109. SPLEEN OF DECEASED

110. PANCREAS OF DECEASED

111. GALLBLADDER OF DECEASED

112. STOMACH OF DECEASED

113. SMALL INTESTINE OF DECEASED

114. LARGE INTESTINE OF DECEASED

115. RECTUM OF DECEASED

116. VAGINA OF DECEASED

117. UTERUS OF DECEASED

118. OVARY OF DECEASED

119. TESTIS OF DECEASED

120. PROSTATE OF DECEASED

121. BLADDER OF DECEASED

122. URETER OF DECEASED

123. PENIS OF DECEASED

124. CLITORIS OF DECEASED

125. VULVA OF DECEASED

126. PERINEUM OF DECEASED

127. ANUS OF DECEASED

128. SKIN OF DECEASED

129. HAIR OF DECEASED

130. NAILS OF DECEASED

131. TEETH OF DECEASED

132. EYES OF DECEASED

133. EARS OF DECEASED

134. NOSE OF DECEASED

135. MOUTH OF DECEASED

136. THROAT OF DECEASED

137. LARYNX OF DECEASED

138. TRACHEA OF DECEASED

139. BRONCHI OF DECEASED

140. LUNGS OF DECEASED

141. HEART OF DECEASED

142. LIVER OF DECEASED

143. SPLEEN OF DECEASED

144. PANCREAS OF DECEASED

145. GALLBLADDER OF DECEASED

146. STOMACH OF DECEASED

147. SMALL INTESTINE OF DECEASED

148. LARGE INTESTINE OF DECEASED

149. RECTUM OF DECEASED

150. VAGINA OF DECEASED

151. UTERUS OF DECEASED

152. OVARY OF DECEASED

153. TESTIS OF DECEASED

154. PROSTATE OF DECEASED

155. BLADDER OF DECEASED

156. URETER OF DECEASED

157. PENIS OF DECEASED

158. CLITORIS OF DECEASED

159. VULVA OF DECEASED

160. PERINEUM OF DECEASED

161. ANUS OF DECEASED

162. SKIN OF DECEASED

163. HAIR OF DECEASED

164. NAILS OF DECEASED

165. TEETH OF DECEASED

166. EYES OF DECEASED

167. EARS OF DECEASED

168. NOSE OF DECEASED

169. MOUTH OF DECEASED

170. THROAT OF DECEASED

171. LARYNX OF DECEASED

172. TRACHEA OF DECEASED

173. BRONCHI OF DECEASED

174. LUNGS OF DECEASED

175. HEART OF DECEASED

176. LIVER OF DECEASED

177. SPLEEN OF DECEASED

178. PANCREAS OF DECEASED

179. GALLBLADDER OF DECEASED

180. STOMACH OF DECEASED

181. SMALL INTESTINE OF DECEASED

182. LARGE INTESTINE OF DECEASED

183. RECTUM OF DECEASED

184. VAGINA OF DECEASED

185. UTERUS OF DECEASED

186. OVARY OF DECEASED

187. TESTIS OF DECEASED

188. PROSTATE OF DECEASED

189. BLADDER OF DECEASED

190. URETER OF DECEASED

191. PENIS OF DECEASED

192. CLITORIS OF DECEASED

193. VULVA OF DECEASED

194. PERINEUM OF DECEASED

195. ANUS OF DECEASED

196. SKIN OF DECEASED

197. HAIR OF DECEASED

198. NAILS OF DECEASED

199. TEETH OF DECEASED

200. EYES OF DECEASED

201. EARS OF DECEASED

202. NOSE OF DECEASED

203. MOUTH OF DECEASED

204. THROAT OF DECEASED

205. LARYNX OF DECEASED

206. TRACHEA OF DECEASED

207. BRONCHI OF DECEASED

208. LUNGS OF DECEASED

209. HEART OF DECEASED

210. LIVER OF DECEASED

211. SPLEEN OF DECEASED

212. PANCREAS OF DECEASED

213. GALLBLADDER OF DECEASED

214. STOMACH OF DECEASED

215. SMALL INTESTINE OF DECEASED

216. LARGE INTESTINE OF DECEASED

217. RECTUM OF DECEASED

218. VAGINA OF DECEASED

219. UTERUS OF DECEASED

220. OVARY OF DECEASED

221. TESTIS OF DECEASED

222. PROSTATE OF DECEASED

223. BLADDER OF DECEASED

224. URETER OF DECEASED

225. PENIS OF DECEASED

226. CLITORIS OF DECEASED

227. VULVA OF DECEASED

228. PERINEUM OF DECEASED

229. ANUS OF DECEASED

230. SKIN OF DECEASED

231. HAIR OF DECEASED

232. NAILS OF DECEASED

233. TEETH OF DECEASED

234. EYES OF DECEASED

235. EARS OF DECEASED

236. NOSE OF DECEASED

237. MOUTH OF DECEASED

238. THROAT OF DECEASED

239. LARYNX OF DECEASED

240. TRACHEA OF DECEASED

241. BRONCHI OF DECEASED

242. LUNGS OF DECEASED

243. HEART OF DECEASED

244. LIVER OF DECEASED

245. SPLEEN OF DECEASED

246. PANCREAS OF DECEASED

CERTIFICATE OF DEATH

Reg. Dist. No. 04185 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>50yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>40I Grand Ave.</u>				STREET ADDRESS (If rural give location) <u>40I Grand Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Guy C. Chadwick</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5 - 4 - 19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Jan 15, 1878</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Bank</u>	11. BIRTHPLACE (State or foreign country): <u>Keyser, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jeremiah Chadwick</u>				14. MOTHER'S MAIDEN NAME: <u>Barbara Roades</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Miss Edna Chadwick 40I Grand Ave.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 Coronary Thrombosis</u>						<u>Acute</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerosis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> to <u>May 4</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>May 2</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Clayton J. Surratt</u>		M. D. <u>Cumberland</u>		DATE SIGNED <u>5/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 5, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Tantz, M.D.</u>		24. FUNERAL DIRECTOR ADDRESS <u>James F. Scarpelli Cumberland, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

041868

4238

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
22 TOWN <u>Frostburg</u>	2 days	TOWN <u>Frostburg</u>	22
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Gerald Paul Close</u>		<u>May 7 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>single</u>	8. DATE OF BIRTH: <u>May 5, 1955</u>
9. AGE last birthday yrs. <u>2</u>		IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Kenneth Close</u>		14. MOTHER'S MAIDEN NAME: <u>Anna P. Blocher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Kenneth Close, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Prematurity</u>			<u>48 hrs</u>
ANTECEDENT CAUSE (S): (B) <u>Toxemia of pregnancy of mother</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 5, 1955</u> , to <u>May 7, 1955</u> , that I last saw the deceased alive on <u>May 7, 1955</u> , and that death occurred at <u>9:10 A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Hilda Sanabria</u>		ADDRESS <u>M. D. Frostburg</u>	
DATE SIGNED <u>5/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-7-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-8-55</u>		REGISTRAR'S SIGNATURE <u>M. Nancy A. Roe</u>	
24. FUNERAL DIRECTOR <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

2055402363

BUREAU V. S.

MAY 13 1955

RECEIVED

Within corporate limits

4131

04187

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>1 Hr.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>204 Arch St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Theodore</u>		(First) <u>F.</u>		(Middle) <u>Dailey</u>		(Last)	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Aug. 14-1867</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Boilermaker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B & O R.R. Ry.</u>		11. BIRTHPLACE (State or foreign country): <u>Martinsburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Dailey</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Gardner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Memorial Hospital records.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.2 Immediate cause (a) <u>Hypostatic congestion of the lungs</u>						24 hrs.	
Antecedent cause(s) (b) <u>Senility</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Chronic myocarditis</u>						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>May 20, 1955</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 19-1955</u>			
DEPUTY MEDICAL EXAMINER <u>V. L. Deming M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>May 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>		24. FUNERAL DIRECTOR <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>			
DATE REC'D BY LOCAL REG. <u>May 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
MAY 24 1955
BUREAU V. S.

RECEIVED

MAY 24 1955

BUREAU V. S.

4195 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		LENGTH OF STAY (in this place) 6yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frostburg		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat				STREET ADDRESS (If rural give location) Mt. Pleasant, St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Maria		(Middle) Longo		(Last) Debelock		(Month) May (Day) 26 (Year) 19 55	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May, 28 18'90	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Edward J. Ryan Frostburg, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE (A) Pulmonary Hypostasis						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Chronis Myscarditis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Arteriosclerosis						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia						6 yrs	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 2, 1952 , to May 26, 1955 , that I last saw the deceased alive on May 26, 1955 and that death occurred at 3:30 PM , from the causes and on the date stated above. SIGNATURE <i>James E. McLean</i> M.D. ADDRESS <i>449 Greene St.</i> DATE SIGNED <i>May 27/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/30/55		NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		LOCATION (City, town, or county) (State) Frostburg, Md.	
24. REC'D BY REGISTRAR May 30, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox- Cumberland, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. No. 111

DEATH CERTIFICATE OF REGISTERED

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		Jan 1, 1900		New York		New York		New York		United States	
MARRIAGE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY			
Married		Married		1920		New York		New York		New York		New York			
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION			
Teacher		Teacher		Teacher		Teacher		Teacher		Teacher		Teacher			
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH			
Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease			
DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE			
Chronic Hypertension		Chronic Hypertension		Chronic Hypertension		Chronic Hypertension		Chronic Hypertension		Chronic Hypertension		Chronic Hypertension			
SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS			
Chest Pain		Chest Pain		Chest Pain		Chest Pain		Chest Pain		Chest Pain		Chest Pain			
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH			
June 2, 1955		June 2, 1955		June 2, 1955		June 2, 1955		June 2, 1955		June 2, 1955		June 2, 1955			
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH			
Home		Home		Home		Home		Home		Home		Home			
CITY		CITY		CITY		CITY		CITY		CITY		CITY			
New York		New York		New York		New York		New York		New York		New York			
STATE		STATE		STATE		STATE		STATE		STATE		STATE			
New York		New York		New York		New York		New York		New York		New York			
COUNTRY		COUNTRY		COUNTRY		COUNTRY		COUNTRY		COUNTRY		COUNTRY			
United States		United States		United States		United States		United States		United States		United States			

BUREAU V. S.

JUN 2 1955

RECEIVED

RECEIVED
JUN 2 1955
BUREAU V. S.

1
Without corporate limits

04189

4196

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		LENGTH OF STAY (in this place) 6 DAYS		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				STREET ADDRESS (If rural give location) 57 N. CENTRE STREET			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ARTHUR B. DICKS				4. DATE OF DEATH (Month) (Day) (Year) MAY 24, 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JULY 27, 1897	9. AGE last birthday 57 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN Appliances		10b. KIND OF BUSINESS OR INDUSTRY POTOMAC EDISON CO.		11. BIRTHPLACE (State or foreign country) WINCHESTER, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SCOTT DICKS				14. MOTHER'S MAIDEN NAME ALICE NICEWARNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 3 No		16. SOCIAL SECURITY NO. 214 10 5568		17. INFORMANT & ADDRESS Harry B. Dicks Cumberland, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
162X IMMEDIATE CAUSE (A) Carcinoma Lung with metastasis						18 months	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Heart Disease						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 19a. 54		19b. MAJOR FINDINGS OF OPERATION Lobectomy, L. upper. Bronchogenic Carcinoma				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 194... 1950, to 24 May, 1955, that I last saw the deceased alive on 24 May, 1955, and that death occurred at 1:25 PM, from the causes and on the date stated above.							
SIGNATURE W. A. Van Orman				ADDRESS (Street, city, town, state) M. D. Cumberland, Md.		DATE SIGNED 25 May 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-27-55		NAME OF CEMETERY OR CREMATORY Mount Hebron Cem.		LOCATION (City, town, or county) (State) Winchester, Va.	
24. REC'D BY REGISTRAR DATE May 26, 1955		REGISTRAR'S SIGNATURE Winters R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md	

CERTIFICATE OF DEATH

NAME OF DECEASED ALICE H. HARRIS		SEX FEMALE		AGE 72	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH JULY 27, 1883		PLACE OF DEATH BALTIMORE, MARYLAND	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
STREET 1111 N. EIGHTH STREET		CITY BALTIMORE		STATE MARYLAND	
COUNTY BALTIMORE		ZIP CODE 21205		DATE OF DEATH MAY 27, 1955	
SIGNATURE OF DECEASED ALICE H. HARRIS		SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE MANNER AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW.

BUREAU V. 8

MAY 27 1955

RECEIVED

CERTIFICATE OF DEATH

04190

Reg. Dist. No. 4

4197

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE WEST VIRGINIA		COUNTY GRANT	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
122 OR TOWN CUMBERLAND		2 DAYS		TOWN GREENLAND		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. (Day) (Year)	
(First) (Middle) (Last) MINOR BROOKS EVANS				MAY 14 19 55			
5. SEX	6. COLOR OR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	AUGUST 26, 1896	58 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
FARMER		Own Farm		STRIEBY, WEST VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES EVANS				ARNIE BECKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
433.1 IMMEDIATE CAUSE (A)				Cerebral Embolus		3 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				Ventricular Fibrillation			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5:14, 19 55, to 5:14, 19 55, that I last saw the deceased alive on 5:14, 19 55, and that death occurred at 6:25 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
W. J. Williams M.D.				Cumberland		5-16-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 17, 1955		Maysville Cemetery		Maysville W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
May 16, 1955		Winter R. Hantz, M.D.		J. Blaine Schaeffer		Petersburg, W. Va.	

INSTRUCTIONS

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VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 100

Usual Residence of Deceased

1111 WEST VIRGINIA

MARYLAND

DATE OF DEATH

2 DAYS

ALLGARY

CORRECTION

MENTAL HOSPITAL

EVANS

BROOKS

THOMAS

WIFE

MARRIED

APRIL 22, 1900

STANLEY, WEST VIRGINIA

WHITE FEMALE

JAMES EVANS

BUREAU V. S.

MAY 24, 1955

RECEIVED

2407027224

NOTICE TO THE PUBLIC: This is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland. It is not to be used for legal purposes without the original record.

4198

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany MARYLAND		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) OR Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary		STREET ADDRESS (If rural give location) 424 Columbia Street	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) Annie Feeley		DATE OF DEATH: May 24, 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	White	Single	12/12/1875
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday
Worker at Footer's & Community Bakery		Cumberland, Maryland	79 yrs. 24 Months 24 Days 55 Hours 55 Min.
13. FATHER'S NAME: Michael Feeley		14. MOTHER'S MAIDEN NAME: Mary Shaughnessey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Allegany County Infirmary Records		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Chronic Myocarditis		?	
ANTECEDENT CAUSE (S) Coronary Arteriosclerosis		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Osteo-artbritis		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Drainage		27 mos	
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Mar 15 55 , to May 24 55 , that I last saw the deceased alive on May 24, 19 55 , and that death occurred at 12:00 P. from the causes and on the date stated above.	
SIGNATURE James M. McLean M.D.		DATE SIGNED 5-25-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27 1955	
NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery		LOCATION (City, town, or county) (State) Cumberland Md	
DATE REC'D BY LOCAL REGISTRAR May 26, 1955		REGISTRAR'S SIGNATURE Walter R. Hanky, M.D.	
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumberland, Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

MAY 27 1955

RECEIVED

1. **Instructions:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04192

4199

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY GARRETT COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND, MD.		LENGTH OF STAY (In this place) 1 DAY		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FRIENDSVILLE		11X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) MAGGIE BLANCHE FRAZEE				4. DATE OF DEATH (Month) (Day) (Year) MAY 26 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAY 22, 1884	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) PRESTON COUNT, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL LINNINGER				14. MOTHER'S MAIDEN NAME REBECCA HAYES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						24	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis						77	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 8		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-4 , 19 46 , to 5:26 , 19 55 , that I last saw the deceased alive on 19 , and that death occurred at 2:00PM from the causes and on the date stated above.							
SIGNATURE M. F. Williams M.D. Cumberland				DATE SIGNED 5-27-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 28, 1955		NAME OF CEMETERY OR CREMATORY Blooming Rose Cem		LOCATION (City, town, or county) (State) Friendsville, Maryland	
24. REC'D BY REGISTRAR May 27, 1955		REGISTRAR'S SIGNATURE Walter R. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J. F. Colburn ADDRESS B. Y. L. W. Colburn			

62-1178

Y. 1211

21195-0143

Y 1571

CONFIDENTIAL

Y. H. H. 1000-9

2300

• 4 •

1024

1112

27 | 333

1991-2000

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1112

2004/01/11 15:42

2-YEAR: 10,733.48

BUREAU A. I.

2 JUN

RECEIVED

4200

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Ma ryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
02 TOWN <u>Cumberland</u>		0mo.		TOWN <u>Cumberland</u> 02			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 314 Frederick St.				314 Frederick St.			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:				
Frances Rebecca Gales			May I 1955				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	Colored	Widowed	4/13/1872	83 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
House Wife		None		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Charles Brown				Annie Marshall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
No			None		William Francis Cumberland, Md.		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Disease</u>							1 day
ANTECEDENT CAUSE (S) (B) <u>Generalized arteriosclerosis</u>							years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from April 30, 1955, to May 1, 1955 that I last saw the deceased alive on May 1, 1955, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schindler</u>			M. D. <u>H. Greenett, Cumberland</u>		DATE SIGNED <u>5/3/55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5/4/55		St. Patrick Cemetery		Cumberland Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 3, 1955		<u>Walter A. [Signature]</u>		Louis Stein, Inc.		Cumberland, Maryland	

MARGIN RESERVED FOR BINDING

BUREAU Y. S.

MAY 6 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04194

4201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Item 8-9 Film 182 6-3-55 at

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY	STATE MARYLAND	STATE W. VA.	COUNTY HARDY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND	LENGTH OF STAY (in this place) 7 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RIG,	(If rural give location) 85 X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last) JOHN D. HARDY		4. DATE OF DEATH (Month) (Day) (Year) MAY 25 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH OCT. 23 17, 1862
9. AGE last birthday 88 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARDY, JOHN		14. MOTHER'S MAIDEN NAME CLAYTON, JOANNA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVE.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 18 May 1955, to 25 May 1955, that I last saw the deceased alive on 25 May 1955, and that death occurred at 2:45 AM, from the causes and on the date stated above.			
SIGNATURE W. A. Van Orman		ADDRESS (Street, city, town, state) Cumberland, Md	
DATE SIGNED 25 May 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1955	
NAME OF CEMETERY OR CREMATORY Scott Cemetery		LOCATION (City, town, or county) (State) Hardy County, West Virginia.	
24. REC'D BY REGISTRAR May 26, 1955		REGISTRAR'S SIGNATURE Walter R. Dantz, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Thrush Funeral Home, Moorefield, W. Va.		ADDRESS	

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3141

3184

1110294

BUREAU V. S.

MAY 27 1971

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

4239

CERTIFICATE OF DEATH

04195

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MAYLAND		STATE <u>md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>72 Frostburg</u>		LENGTH OF STAY (in this place) <u>17 mo 2 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Red Hill</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt 1 Cumberland</u>			
3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>Hayes</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb 20 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Month Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseworks</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Old Age Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Wm Myers, Cumb Rt 1</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>170X</u>				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma Lungs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Right breast</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 28, 19 55</u> , to <u>May 19, 19 55</u> , that I last saw the deceased alive on <u>May 19, 19 55</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg, Md</u>		DATE SIGNED <u>5/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eckhart Mines Md</u>	
24. REC'D BY REGISTRAR <u>Ms Nancy A. Rose</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hefner</u>		ADDRESS <u>Cumberland Md</u>	
DATE <u>5-21-55</u>							

CERTIFICATE OF DEATH

Decedent: *John J. [illegible]*
Age: *73*
Sex: *Male*
Race: *White*
Marital Status: *Married*
Place of Birth: *Washington, D.C.*
Usual Residence: *1215 [illegible] St. N.W.*
Cause of Death: *Myocardial Infarction*
Date of Death: *Feb 20 1955*
Time of Death: *10:30 AM*
Place of Death: *Home*
Physician: *Dr. [illegible]*
Manner of Death: *Natural*
Burial Place: *St. [illegible] Church*

BUREAU V. S.

MAY 27 1955

RECEIVED

John J. [illegible] 1215 [illegible] St. N.W. Washington, D.C.

04196

4202

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN Cumberland</u>		LENGTH OF STAY (in this place) <u>2 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>605 Greene St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Martha</u> (Middle) <u>S.</u> (Last) <u>Hersh</u>				(Month) <u>May</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Jan. 26, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Meyersdale</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Deceased Adam Sipple</u>				14. MOTHER'S MAIDEN NAME <u>Deceased Margaret Finzel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No, /</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Son: William Hersh Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> IMMEDIATE CAUSE (A) <u>apoplectic stroke</u>				<u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterial hypertension</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis</u>				<u>2 years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-2-</u> , 19 <u>53</u> , to <u>5-16-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-14-</u> , 19 <u>55</u> , and that death occurred at <u>6:45</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>L. Prinos</u>				ADDRESS (Street, city, town, state) <u>57 Greene St., Cumberland Md</u>		DATE SIGNED <u>5-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>May 19, 1955</u>		REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Print or write)

9. Place of death (City, State, Country)

10. Signature of attending physician (Print or write)

11. Signature of registrar (Print or write)

12. Signature of medical examiner (Print or write)

13. Signature of coroner (Print or write)

14. Signature of funeral director (Print or write)

15. Signature of undertaker (Print or write)

16. Signature of cemetery (Print or write)

17. Signature of burial place (Print or write)

18. Signature of interment place (Print or write)

19. Signature of cremation place (Print or write)

20. Signature of disposition (Print or write)

21. Signature of disposition (Print or write)

22. Signature of disposition (Print or write)

23. Signature of disposition (Print or write)

24. Signature of disposition (Print or write)

25. Signature of disposition (Print or write)

26. Signature of disposition (Print or write)

27. Signature of disposition (Print or write)

28. Signature of disposition (Print or write)

29. Signature of disposition (Print or write)

30. Signature of disposition (Print or write)

BUREAU V. 3

MAY 24 1955

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the attending physician, registrar, medical examiner, coroner, funeral director, undertaker, cemetery, interment place, cremation place, or disposition place. 2. The name of the deceased should be printed or written in full. 3. The sex should be indicated by "M" for male or "F" for female. 4. The date of birth should be given in full. 5. The place of birth should be given in full. 6. The usual residence should be given in full. 7. The date of death should be given in full. 8. The time of death should be given in full. 9. The cause of death should be given in full. 10. The place of death should be given in full. 11. The signature of the attending physician should be given in full. 12. The signature of the registrar should be given in full. 13. The signature of the medical examiner should be given in full. 14. The signature of the coroner should be given in full. 15. The signature of the funeral director should be given in full. 16. The signature of the undertaker should be given in full. 17. The signature of the cemetery should be given in full. 18. The signature of the interment place should be given in full. 19. The signature of the cremation place should be given in full. 20. The signature of the disposition place should be given in full. 21. The signature of the disposition place should be given in full. 22. The signature of the disposition place should be given in full. 23. The signature of the disposition place should be given in full. 24. The signature of the disposition place should be given in full. 25. The signature of the disposition place should be given in full. 26. The signature of the disposition place should be given in full. 27. The signature of the disposition place should be given in full. 28. The signature of the disposition place should be given in full. 29. The signature of the disposition place should be given in full. 30. The signature of the disposition place should be given in full.

4249

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. 04197

No 8

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Lonaconing</u>				TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Charlestown St.</u>				STREET ADDRESS (If rural, give location) <u>Charlestown St.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Robert</u>		(Middle) <u>Gerstell</u>		(Last) <u>Hershberger</u>		(Month) <u>May</u> (Day) <u>22</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>Jan. 15-1901</u>	
9. AGE last birthday: <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Elk Garden, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>James Hershberger</u>			
14. MOTHER'S MAIDEN NAME: <u>Adeline Snider</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1919-21</u>			
16. SOCIAL SECURITY No.: <u>215-10-4377</u>				17. INFORMANT & ADDRESS: <u>Lonaconing, Md. (wife) Rachael Leese Hershberger</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				sudden	
(a) <u>Intrathoracic hemorrhage</u>					
Immediate cause DUE TO					
Antecedent cause(s) <u>12 gauge shotgun wound in left chest,</u>					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c) <u>self inflicted.</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Despondent due to ill health.</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY) <u>Home</u>		21c. (City or town) (County) (State) <u>Lonaconing Allegany Md.</u>	
21d. TIME (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1955</u> (Hour) <u>A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot himself in bed-room at his home.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 22-1955</u>			
H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>PHILOS CEMETERY</u>	
LOCATION (City, town, or county) (State) <u>WESTERNPORT, MD.</u>		24. FUNERAL DIRECTOR <u>George Eichhorn, Lonaconing, MD.</u>			
DATE REC'D BY LOCAL REG. <u>May 25 1955</u>		REGISTRAR'S SIGNATURE <u>Jeanette M. Boal</u>			

BUREAU V. S.

MAY 27 1955

RECEIVED

RECEIVED

RECEIVED

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04198

4203

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>45yrs</u>		TOWN <u>Cumberland, Md.</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Virginia Ave.</u>				STREET ADDRESS (If rural give location) <u>9 Virginia Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u> (Middle) <u>Henritta</u> (Last) <u>Hession</u>				(Month) <u>5</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>May 9, 1866</u>	<u>89</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Grafton, W. Va.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John L. Kenney</u>				<u>Eliza Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4 No</u>		<u>None</u>		<u>Adelaide Hession 9 Virginia Ave</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						<u>1 DA.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>30 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Advanced age</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>none</u>		<u>none</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<u>none</u>		<u>none</u>		<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>Jan 3</u> to <u>May 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-19-55</u> , 19 <u>55</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John Hallen</u>				ADDRESS (Street, city, town, state) <u>140 Bedford St Cumberland Md.</u>		DATE SIGNED <u>5/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>5-23-55</u>		<u>St Peter & Paul Cem.</u>		<u>Cumberland, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 20, 1955</u>		<u>Winter R. Frank, M.D.</u>		<u>James F. Scarpelli</u>		<u>Cumberland, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form No. 10-1

1. Name of Deceased (Print Name)

2. Sex

3. Age

4. Race

5. Date of Birth

6. Date of Death

7. Place of Death

8. Cause of Death

9. Duration of Illness

10. Name of Physician

11. Name of Hospital

12. Name of Undertaker

13. Name of Coroner

14. Name of Registrar

15. Name of Burial Place

16. Name of Cemetery

17. Name of Interment

18. Name of Burial

19. Name of Burial

20. Name of Burial

21. Name of Burial

22. Name of Burial

23. Name of Burial

24. Name of Burial

25. Name of Burial

26. Name of Burial

27. Name of Burial

28. Name of Burial

29. Name of Burial

30. Name of Burial

31. Name of Burial

32. Name of Burial

33. Name of Burial

34. Name of Burial

35. Name of Burial

BUREAU V. 1

MAY 24 1955

RECEIVED

42-4

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 02 Cumberland		LENGTH OF STAY (In this place) 93 years		CITY (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 512. Ridgewood Ave				STREET ADDRESS (If rural give location) 512. Ridgewood Ave			
3. NAME OF DECEASED: (First) Mary (Middle) Virginia (Last) Hinkle				4. DATE (Month) (Day) (Year) OF DEATH: May 13 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: June 14 1861	9. AGE last birthday: 93 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own House		11. BIRTHPLACE (State or foreign country): Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John C. Wentling				14. MOTHER'S MAIDEN NAME: Martha Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 4 No		16. SOCIAL SECURITY NO.: None		17. INFORMANT & ADDRESS: Virgil D. Hinkle, Cumberland Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.0				Myocardial failure 4 mo.			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Generalized vascular failure 4 mo.			
				Arteriosclerotic Heart Disease 30 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Advanced age							
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION: none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none		21C. WHERE DID (City or town) INJURY OCCUR? none		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY none M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 10, 1955 to May 13, 1955 , that I last saw the deceased alive on MAY 13, 1955 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE J. F. Haeccinan md				ADDRESS 140 Bedford St. Cumberland, Md.			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial		DATE THEREOF May 16 1955		NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		LOCATION (City, town, or county) (State) Cumberland Md.	
DATE REC'D BY LOCAL REGISTRAR May 16, 1955		REGISTRAR'S SIGNATURE Walter R. Tantz, M.D.		24. FUNERAL DIRECTOR William H. Kight		ADDRESS Cumberland, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1955
BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

4205

CERTIFICATE OF DEATH

04200

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	ALLEGANY	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)	CUMBERLAND	COUNTY	ALLEGANY
OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	CUMBERLAND, rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS	MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,	STREET ADDRESS (If rural give location)	RT. #2, BOX 433
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
MILINDA C		MAY 10 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
FEMALE	WHITE	MARRIED	JULY 9, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
HOUSEWIFE		Own Home	OLDTOWN, MARYLAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN J. PIPER		NANCY WAGNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
NO		None	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Memorial Hospital		DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		IMMEDIATE CAUSE (A) CEREBRAL INFARCTION	
		ANTECEDENT CAUSE(S) DUE TO (B) CEREBRAL THROMBOSIS	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) ARTERIOSCLEROSIS, GENERAL	
		11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
0			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/8, 1955, to 5/10, 1955, that I last saw the deceased alive on 5/9, 1955, and that death occurred at 8:55A.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
H. C. Cressman M.D.		Cumberland Md	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		May 12, 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
SS: Peter & Paul		Cumberland, Md.	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
May 12, 1955		James F. Scarpelli, Cumberland, Md.	

Within corporate limits

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04201

4206

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND, MD.		40 DAYS		CITY CUMBERLAND, MARYLAND <i>rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL		STREET ADDRESS (If rural give location)			
60		MEMORIAL AVE.		RT. #2 WILLIAMS RD.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
CAROL JEAN IZZETT				MAY 8, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	SINGLE	DEC. 15, 1942	12 yrs.	Month	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
child				NONE			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Carbondale, Pennsylvania				U. S. A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
JAMES R. IZZETT				JEAN WAGNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
4 NO				NONE			
17. INFORMANT & ADDRESS:							
James Izzett, Rt. 2, Cumberland, Md.							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 199.1							
DUE TO Neurofibrosarcoma of neck						15 mo.	
ANTECEDENT CAUSE (S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						None	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
Apr 1954		Mass in neck (neurofibrosarcoma)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr , 1954, to May 8 , 1955, that I last saw the deceased alive on May 8, 1955 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Dr. Mirkin		M. D. Cumberland		5-9-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 14, 1955		Hillcrest Burial Park		Cumberland, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 10, 1955		Walter R. Hawley, M.D.		John T. Hafer, Cumberland, Md.			

RECEIVED

MAY 16 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4250

04202
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 8

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lonaconing</u>		LENGTH OF STAY (in this place) <u>75 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miller Apt. W. Main St.</u>				STREET ADDRESS (If rural, give location) <u>Miller Apt. W. Main St.</u>			
3. NAME OF DECEASED: (First) <u>Clara</u>		(Middle) <u>C.</u>		(Last) <u>Jones</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>7</u> (Year) <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH: <u>Jan. 3-1880</u>		9. AGE last birthday: <u>75</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Francis Thomas Fazenbaker</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Isabell Spiker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Hugh Fazenbaker, Lonaconing, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>							
DUE TO							
Antecedent cause(s) (b) <u>Arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						sudden about 10 years.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 9-1955</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May, 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
DATE REC'D BY LOCAL REG. <u>5-12-55</u>		REGISTRAR'S SIGNATURE <u>Jannette M. Boal</u>		24. FUNERAL DIRECTOR <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

BUREAU V. S.

MAY 18 1955

RECEIVED

THOMAS W. BARNETT, JR.,
FEDERAL BUREAU OF INVESTIGATION,
WASHINGTON, D. C.

MAY 18 1955

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

.04203

4207

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		1 DAY		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL				715 FREDERICK STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
MARVIN W. KEITER				MAY 11 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	JULY 14, 1903	51 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
GROCERER		OWN Grocery Store		VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES W. KEITER				ETTA MAE MARSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		214 05 6305		MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				Since			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)				april 54			
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-7-54, 1954, to 5-11-55, 1955, that I last saw the deceased alive on 5-11-55, 1955, and that death occurred at 5:42P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Wm. J. Williams M.D.						5-12-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		May 14, 1955		Hill Crest Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
May 12, 1955		Winter R. Fantz, M.D.		Byron Light		Cumberland, Md.	

1

04204

4208 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH Allegany COUNTY				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany				
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN Cumberland			LENGTH OF STAY (in this place) 2 days			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland 02		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital			STREET ADDRESS (If rural give location) Queen City Pavement Hammersmith's Rest					
3. NAME OF DECEASED (Type or Print) Earl J. Kraus				4. DATE OF DEATH (Month) May (Day) 8 (Year) 1955				
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH March 20, 1891		9. AGE last birthday 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Cumberland, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gottlieb Kraus				14. MOTHER'S MAIDEN NAME Julia Schaffer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-05-5135		17. INFORMANT & ADDRESS Mrs Alice Henderson 41 Browning St				
18. MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
587.0 IMMEDIATE CAUSE (A) coronary disease								3 days
ANTECEDENT CAUSE(S) DUE TO (B) pneumonia								3 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)								
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION 0				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from May 5, 1955, to May 5, 1955, that I last saw the deceased alive on May 5, 1955, and that death occurred at 4:15 P.M. from the causes and on the date stated above.								
SIGNATURE B. M. Schindler				M.D. J. J. Brown		DATE SIGNED 5/19/55		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-II-55		NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem.		LOCATION (City, town, or county) (State) Cumberland, Md.		
24. REC'D BY REGISTRAR May 9, 1955		REGISTRAR'S SIGNATURE Winter R. Traub		25. FUNERAL DIRECTOR'S SIGNATURE J. J. Brown		ADDRESS Cumberland, Md.		

CERTIFICATE OF DEATH

Form 10-1-55

1. LOCAL RESIDENCE (Name of Decedent)

2. PLACE OF DEATH (Name of Hospital, etc.)

3. MARITAL STATUS

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. RACE

13. COLOR

14. HEIGHT

15. WEIGHT

16. BLOOD TYPE

17. EDUCATION

18. RELIGION

19. SOCIAL SECURITY NUMBER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF PHYSICIAN

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF CLERK

27. SIGNATURE OF NOTARY

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF JAILER

31. SIGNATURE OF WARDEN

32. SIGNATURE OF CHIEF OF POLICE

33. SIGNATURE OF DETECTIVE

34. SIGNATURE OF OFFICER

35. SIGNATURE OF SGT.

36. SIGNATURE OF CAPT.

37. SIGNATURE OF MAJOR

38. SIGNATURE OF LIEUTENANT

39. SIGNATURE OF SERGEANT

40. SIGNATURE OF PRIVATE

41. SIGNATURE OF CORP.

42. SIGNATURE OF PVT.

43. SIGNATURE OF SGT.

44. SIGNATURE OF CAPT.

45. SIGNATURE OF MAJOR

46. SIGNATURE OF LIEUTENANT

47. SIGNATURE OF SERGEANT

48. SIGNATURE OF PRIVATE

49. SIGNATURE OF CORP.

50. SIGNATURE OF PVT.

51. SIGNATURE OF SGT.

52. SIGNATURE OF CAPT.

53. SIGNATURE OF MAJOR

54. SIGNATURE OF LIEUTENANT

55. SIGNATURE OF SERGEANT

56. SIGNATURE OF PRIVATE

57. SIGNATURE OF CORP.

58. SIGNATURE OF PVT.

BUREAU V. S.

MAY 16 1955

RECEIVED

ENCLOSURE

NOTES: This certificate is to be filled out by the physician or coroner who has examined the body and determined the cause of death. It is to be filed in the office of the Registrar of the State Department of Health. A copy of this certificate is to be sent to the family of the deceased. The certificate is valid for a period of 30 days from the date of death.

4209

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Allegany MARYLAND			STATE Maryland COUNTY Allegany		
CITY (If outside corporate limits, write RURAL OR and give nearest town) 02 Cumberland			CITY (If outside corporate limits, write RURAL and give nearest town) OR 02 Cumberland		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary			STREET ADDRESS (If rural give location) 1 818 Columbia Avenue		
3. NAME OF DECEASED: (Type or Print)			4. DATE (Month) (Day) (Year) OF DEATH:		
(First) Robert (Middle) Alvin (Last) Lanham			May 1, 1955		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 4/22/1886	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Maint. Man			10B. KIND OF BUSINESS OF INDUSTRY: Rosenbaum Dept. Store		
11. BIRTHPLACE (State or foreign country): Virginia, Culpepper			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Manley A. Lanham			14. MOTHER'S MAIDEN NAME: Martha Wine		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 3 No (If Yes, give war or dates of service)			16. SOCIAL SECURITY No. 214-05-8268		
17. INFORMANT & ADDRESS: Allegany County Infirmary Records					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE 420.1					
ANTECEDENT CAUSE (S):					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.					
(A) DUE TO Coronary Thrombosis					8 hrs
(B) DUE TO Chronic myocarditis					?
(C) DUE TO General arteriosclerosis					?
Bronchial Asthma					?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 14, 1954 , to May 1, 1955 that I last saw the deceased alive on Apr. 30, 1955 and that death occurred at 3:05 PM , from the causes and on the date stated above.					
SIGNATURE James E. McLean		M. D. 49 Penn St.		DATE SIGNED 5-2-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF May 4 1955		NAME OF CEMETERY OR CREMATORY Cedar Hill Crematorium LOCATION (City, town, or county) (State) Washington, D.C.	
DATE REC'D BY LOCAL REGISTRAR May 3, 1955		REGISTRAR'S SIGNATURE Walter R. Lang, M.D.		24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 5 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04206

4251

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Luke</u>		<u>48 yrs</u>		TOWN <u>Luke</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>405 Pratt Street</u>				STREET ADDRESS (If rural give location) <u>405 Pratt Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>JOSEPH</u> (Middle) <u>WARREN</u> (Last) <u>LA RUE</u>				<u>May 27</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 16, 1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beaterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Millville, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Moses P. LaRue</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Medler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-0454 A</u>		17. INFORMANT & ADDRESS <u>Mrs. Gladys Grove, Cumberland, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>79 Days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Edema</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 18</u> , 19 <u>55</u> , to <u>May 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>55</u> , and that death occurred at <u>10:12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul B. Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u>		DATE SIGNED <u>May 29, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>	
24. REC'D BY REGISTRAR <u>5-29-55</u>		REGISTRAR'S SIGNATURE <u>Miss Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal-Westernport, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

REG. GEN. NO.

1. HUSBAND, WIFE, CHILD, OR OTHER DEPENDENT

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. PLACE OF INTERMENT

12. NAME OF FUNERAL HOME

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESSES

RECEIVED

BUREAU V. 21

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4240

CERTIFICATE OF DEATH

Reg. Dist. No. 04207 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frostburg, Md.</u> 21			
TOWN <u>Frostburg</u>				STREET ADDRESS (If rural give location) <u>95 Bowery St</u> 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Brenda Kay Lashbaugh</u>				<u>May 18th 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>May 16th, 1955</u>		<u>3</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Ralph C. Lashbaugh</u>				<u>Mary Margaret Leasure</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
					<u>95 Bowery St., Mary M. Leasure Frostburg, Md.</u>		
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>HEMORRHAGIC DISEASE OF NEW BORN CAUSE</u>						<u>1 DAY</u>	
ANTECEDENT CAUSE (S) (B) <u>UNKNOWN</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 14</u> , 19 <u>55</u> , to <u>5 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5 19</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P (4:00 P)</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John C. Diner</u>		M.D. <u>Frostburg</u>		ADDRESS <u>23 E. Main</u>		DATE SIGNED <u>5/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/19/55</u>		<u>Frostburg Memorial Park, Frostburg, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>5-19-55</u>		<u>Mrs. Nancy A. Roe</u>		<u>Bessie H. Winters Frostburg, Md.</u>			

2055326364

RECEIVED

MAY 27 1955

BUREAU V. 3

4210

CERTIFICATE OF DEATH

04208

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE WEST VIRGINIA		COUNTY Hampshire	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 16 HRS. 15 MIN.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GREEN SPRING, W.VA.		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) RUTH (Middle) NAOMI (Last) LEASE				4. DATE OF DEATH (Month) MAY (Day) 14 (Year) 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DEC. 15, 1902	9. AGE last birthday 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARNOLD G. CLARK				14. MOTHER'S MAIDEN NAME ELIZABETH GROVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Intestinal obstruction				INTERVAL BETWEEN ONSET AND DEATH 5 days			
ANTECEDENT CAUSE(S) DUE TO (B) Pelvic adhesions				Longer			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Post operative and anesthetic shock				1 hr.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 13-14-55		19b. MAJOR FINDINGS OF OPERATION Obstructed terminal ileum		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-13, 1955, to 5-14, 1955, that I last saw the deceased alive on 5-14, 1955, and that death occurred at 9:45 AM, from the causes and on the date stated above.							
SIGNATURE J. H. H. H.		DATE THEREOF May 17 1955		NAME OF CEMETERY OR CREMATORY Mineral Baptist Cemetery		LOCATION (City, town, or county) Near Fort Ashby, W. Va.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 17 1955		NAME OF CEMETERY OR CREMATORY Mineral Baptist Cemetery		LOCATION (City, town, or county) Near Fort Ashby, W. Va.	
24. REC'D BY REGISTRAR May 14, 1955		REGISTRAR'S SIGNATURE Winters R. Tandy, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE M. D. Keith Sheffer		ADDRESS	

CERTIFICATE OF DEATH

6210

Reg. Dist. No.

1. PLACE OF DEATH

WEST VIRGINIA

MARYLAND

ALLEGANY

WEST VIRGINIA

MARYLAND

ALLEGANY

EMERALD HOSPITAL
SPECIAL NURSING UNIT

LEASE

INCH

INCH

ED. 12

ED. 12

ED. 12

ED. 12

ELIZABETH GROVE

ELIZABETH GROVE

3 days
in year

Historical observation
before admission -
Postoperative and normal for 1 hr

BUREAU V. S.

2-14-52 reoperation removed lesion

MAY 17 1952

RECEIVED

2-12-52 2-14

2-14-52

1/11/52

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04209

4241

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>22 Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>22 Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 131 Bowery Street</u>		STREET ADDRESS (If rural give location) <u>131 Bowery St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LILLIAN MAE (PLUMMER) LEWIS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 1, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>July 5, 1920</u>
9. AGE last birthday: <u>34</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Emory Plummer</u>		14. MOTHER'S MAIDEN NAME: <u>Mary E. Devore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>218-34-4411</u>	
17. INFORMANT & ADDRESS: <u>Harold Lewis, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of Uterus</u>		<u>2 yrs.</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>UREMIA</u>			
19A. DATE OF OPERATION: <u>1 SEPT. 1952</u>		19B. MAJOR FINDINGS OF OPERATION: <u>CARCINOMA OF CERVIX OF UTERUS</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> to <u>5/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/1/55</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Mary E. Devore</u>		DATE SIGNED <u>5/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-4-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town or county) (State) <u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-4-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>	
24. FUNERAL DIRECTOR <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

REFERENCE: [Illegible]

ACTION: [Illegible]

INITIALS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

REFERENCE: [Illegible]

ACTION: [Illegible]

INITIALS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

REFERENCE: [Illegible]

ACTION: [Illegible]

INITIALS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

REFERENCE: [Illegible]

ACTION: [Illegible]

INITIALS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

REFERENCE: [Illegible]

ACTION: [Illegible]

INITIALS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

REFERENCE: [Illegible]

ACTION: [Illegible]

INITIALS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

CHARACTER: [Illegible]

CLASSIFICATION: [Illegible]

RECEIVED
MAY 9 1955
BUREAU V. S.

4211

04210

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

I. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland LENGTH OF STAY (In this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) Rural) Narrows Park, Cumberland, Md.
 STREET ADDRESS (If rural, give location) R.F.D. #6

3. NAME OF DECEASED:

(First) Gene (Middle) Lee (Last) Lockard

4. DATE OF DEATH (Month) (Day) (Year)
May 19 19 55

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH:

March 19-1955

9. AGE last birthday:

Qrs. 2 Months 2 Days 19 Hours 55 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Elizabeth Lockard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

Allegany Co. Welfare, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Status Thymico lymphaticus

DUE TO

Antecedent cause(s)

(b) Pulmonary edema (marked)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 2 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED May 19-1955
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☒

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 5/21/55

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. May 20, 1955

REGISTRAR'S SIGNATURE A.R. Nantz, M.D.

24. FUNERAL DIRECTOR

ADDRESS

John J. Hafer, Cumberland, Maryland

2035192416

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 24 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4212

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>allegany</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Flutstone Route 1</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crump Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Emmaline</u>		(Middle)		(Last) <u>Martin</u>		4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>May 1, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Bedford Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>George W. Martin</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Shipley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Wm C. Martin Rt 1 Flutstone</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>						3 years	
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerosis</u>						4 4	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 55</u> , 19 <u>55</u> , to <u>May 7 55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 55</u> , 19 <u>55</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. M. Treaskis, Jr</u>		ADDRESS <u>M. D. Cumberland, Md</u>		DATE SIGNED <u>5/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 10 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem</u>		LOCATION (City, town, or county) (State) <u>Artemas Pa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		24. FUNERAL DIRECTOR <u>John J. Hofer</u>		ADDRESS <u>Cumberland Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

DR. WEISMAN 4213 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		46 DAYS		TOWN CUMBERLAND Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
60 MEMORIAL HOSPITAL				RT. #2, WILLIAMS ROAD			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) SUSAN		(Middle) MAY		(Day) 7		(Year) 19 55	
(Type or Print)							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	MARRIED	MARCH 11, 1847	108 yrs.	Months	Days	Hours
							Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
House Wife				WEST VIRGINIA		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
JOHN HOWDERSHELL				ELIZABETH DERM			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):				15. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
4 No (If Yes, give war or dates of service)				None		MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332x IMMEDIATE CAUSE				(A) Cerebral Infarction			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) Thrombosis of Cerebral Arteries			
				DUE TO			
				(C) Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
				M.		Struck by car	
22. I hereby certify that I attended the deceased from Mar 21, 1955 , to May 7, 1955 , that I last saw the deceased alive on May 7, 1955 , and that death occurred at 10:45 M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
Dr. Weisman				M. D. Cumberland		5/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 10, 1955		Mt. Herman Cemetery		Allegany County, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 9, 1955		Walter R. Huntz, M.D.		Louis Stein, Inc.		Cumberland, Md.	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 16 1955

RECEIVED

04213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4242

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS <u>99 Broadway</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES W. MILLER</u>		4. DATE OF DEATH <u>MAY 3 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAY 14, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	9. AGE last birthday <u>74</u> yrs.
13. FATHER'S NAME <u>George Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>220-26-9442</u>	
17. INFORMANT <u>Thomas B. Jones, Frostburg, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Long</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>420.1 CORONARY Occlusion</u>			<u>3 hrs.</u>
Antecedent cause(s) (b) <u>Chronic Cardiovascular disease</u>			<u>years.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1950, to May 3, 1955, that I last saw the deceased alive on May 3, 1955, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

SIGNATURE <u>John B. Davis, M.D.</u>		ADDRESS <u>Frostburg, Md.</u>		DATE SIGNED <u>5/3/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5-6-55</u>	NAME OF CEMETERY OR CREMATORY <u>White Oak Cemetery</u>	LOCATION <u>Waltersburg, Pa.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>5-5-55</u>	REGISTRAR'S SIGNATURE <u>M. Nancy N. Roe</u>	24. FUNERAL DIRECTOR <u>Johnston Funeral Home, Berlin, Pa.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 9 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland LENGTH OF STAY (in this place) 3 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 828 Lafayette Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS (If rural, give location) 828 Lafayette Ave.

3. NAME OF DECEASED: (First) Michael (Middle) Alfred (Last) Miller 4. DATE OF DEATH (Month) (Day) (Year) May 14 19 55

5. SEX: male 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower 8. DATE OF BIRTH: March 5-1877 9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life) Retired Coal miner 10b. KIND OF BUSINESS OR INDUSTRY: Retired Coal miner 11. BIRTHPLACE (State or foreign country): near-Burlington, W.Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Alexander Miller

14. MOTHER'S MAIDEN NAME:

Matilda Blackburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) about 1920

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

(son) Howard Miller, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1
Immediate cause

(a) Congestive heart failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Cardio-vascular disease

DUE TO

(c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

sudden

10 yrs.

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 0 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED May 14-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF May 17 1955

NAME OF CEMETERY OR CREMATORY Vale Summit Methodist Cem, Vale Summit, Md

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. May 16, 1955

REGISTRAR'S SIGNATURE Walter K. Hantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1955
BUREAU V. S.

04215

4215

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>9 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BARRELLVILLE, MD.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 SACRED HEART HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>216 BLOOMING ST.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u>		(Middle) <u>F.</u>		(Last) <u>Morgan</u>		(Day) <u>5</u>	
(Type or Print)						(Year) <u>19 55</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>10-6-1898</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Helen Templeton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-0639</u>		17. INFORMANT & ADDRESS <u>Eva Morgan, Barrellville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Info cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Certain sclerotic heart disease</u>				<u>2 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>carcinoma of the Liver with ascites</u>				<u>9 mo.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) <u>none</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>June 16, 19 55</u> to <u>May 14, 19 55</u> , that I last saw the deceased alive on <u>May 14, 19 55</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. P. Vallanar</u>		ADDRESS (Street, city, town, state) <u>140 Bedford St. Cumberland, Md.</u>		DATE SIGNED <u>5/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>May 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Huntz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. George</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C (1-55) 10M

CERTIFICATE OF DEATH

REG. NO. 1001

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

BUREAU V. S.

MAY 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4243

CERTIFICATE OF DEATH

Reg. Dist. No.

04216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
22 TOWN <u>Frostburg</u>		20 hrs.		TOWN <u>Frostburg</u> 22			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital</u>				52 W. Main St. 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
(Type or Print) <u>MAGDALENA K. MULLER</u>				<u>May 3, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>June 4, 1889</u>	<u>65</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>housework</u>			<u>own home</u>		<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Keller</u>				<u>Anna Kocia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>none</u>				<u>none</u>		<u>John Keller, Frostburg, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE						<u>2 days.</u>	
ANTECEDENT CAUSE (S)						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						—	
(A) <u>Acute myocardial infarct.</u>							
DUE TO							
(B) <u>Chronic myocarditis</u>							
DUE TO							
(C) <u>Arterio-sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>55</u> , to <u>5-3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-3</u> , 19 <u>55</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>H.C. Diehl</u>		<u>Frostburg, Md.</u>		<u>5/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-6-1955</u>		<u>Zion Evan. & Ref. Cemetery</u>		<u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-6-55</u>		<u>My. Harvey A. Roe</u>		<u>J. R. Durst,</u>		<u>Frostburg, Md.</u>	

RECEIVED
MAY 9 1955
BUREAU V. S.

1. This is a corporate limit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4216

CERTIFICATE OF DEATH

04217

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		STATE <u>WEST VIRGINIA</u> COUNTY <u>MINERAL</u>			
CITY OR TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>9 hrs.</u>		CITY OR TOWN <u>RIDGELEY</u>		CITY OR TOWN <u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>				STREET ADDRESS <u>22 BRIDGE STREET</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>SARAH ESTHER MURPHY</u>				<u>5-31-55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>April 16, 1906</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael J. Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Daugherty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Francis D. Murphy 121 Arch St.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary heart failure</u>						<u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>rheumatic heart</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>now</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-4-</u> , 19 <u>55</u> , to <u>5-31-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-30-</u> , 19 <u>55</u> , and that death occurred at <u>7:30 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>576 Green St. Cumberland Md</u>		DATE SIGNED <u>5-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>Walter R. Tantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>James F. Scarpelli Cumberland, Md</u>	

CERTIFICATE OF DEATH

Form No. 1

GENERAL INSTRUCTIONS (FURNISH TO REGISTRAR)

1. Name of deceased (Print or write full name)
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Usual residence (Print or write full name)
7. Cause of death (Print or write full name)
8. Date of death
9. Time of death
10. Signature of registrar

11. Signature of physician
12. Signature of coroner
13. Signature of undertaker
14. Signature of funeral home
15. Signature of cemetery

16. Signature of health officer
17. Signature of registrar
18. Signature of funeral home
19. Signature of cemetery

20. Signature of health officer
21. Signature of registrar
22. Signature of funeral home
23. Signature of cemetery

24. Signature of health officer
25. Signature of registrar
26. Signature of funeral home
27. Signature of cemetery

28. Signature of health officer
29. Signature of registrar
30. Signature of funeral home
31. Signature of cemetery

32. Signature of health officer
33. Signature of registrar
34. Signature of funeral home
35. Signature of cemetery

36. Signature of health officer
37. Signature of registrar
38. Signature of funeral home
39. Signature of cemetery

BUREAU V. S.

JUN 3 19

RECEIVED

4217

CERTIFICATE OF DEATH

04218

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEAR Cumberland, RURAL</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEAR Cumberland, RURAL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>915 National Highway LaVale, Md.</u>				STREET ADDRESS (If rural give location) <u>915 National Highway LaVale, Md.</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles L Myers</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 28 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>2/14/1893</u>	
9. AGE last birthday <u>62</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles H Myers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mathews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Robert Weires LaVale, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>443X Hypertension, Ch. degeneration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral atrophy</u>				<u>8 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension, arteriosclerosis</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5/27</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1930</u> , to <u>5/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>55</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above. <u>5/29/55</u> SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>49 Green St. Cumberland Md.</u> DATE SIGNED <u>5/29/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>June 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hartz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

1955

Form 100-1

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Manner of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of funeral director

15. Signature of medical examiner

16. Signature of coroner

17. Signature of justice of the peace

18. Signature of health officer

19. Signature of local health officer

20. Signature of local health officer

21. Signature of local health officer

22. Signature of local health officer

23. Signature of local health officer

24. Signature of local health officer

25. Signature of local health officer

26. Signature of local health officer

27. Signature of local health officer

28. Signature of local health officer

29. Signature of local health officer

30. Signature of local health officer

31. Signature of local health officer

32. Signature of local health officer

33. Signature of local health officer

34. Signature of local health officer

35. Signature of local health officer

36. Signature of local health officer

37. Signature of local health officer

38. Signature of local health officer

39. Signature of local health officer

40. Signature of local health officer

41. Signature of local health officer

42. Signature of local health officer

43. Signature of local health officer

BUREAU V. S.

JUN 3 1955

RECEIVED

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04219

4218

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>Cumberland, Md</u>		LENGTH OF STAY (in this place) <u>65 years</u>		TOWN <u>Cumberland, Md.</u>		TOWN <u>Cumberland, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>822 Gephart Drive</u>				STREET ADDRESS (If rural give location) <u>822 Gephart Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Leslie Wilson Nave</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 22, 1875</u>	
9. AGE last birthday <u>79</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (State or foreign country) <u>Centerville, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teller</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>			
13. FATHER'S NAME <u>Elza W. Nave</u>				14. MOTHER'S MAIDEN NAME <u>Rena Laney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-14-4017</u>		17. INFORMANT & ADDRESS <u>Louise M. Nave-822 Gephart Dr.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0 Atherosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yea.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5-10</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>6-22-54</u> , 19 <u>54</u> , to <u>5-10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-10</u> , 19 <u>55</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Ralph W. Baccin</u> M.D. <u>Cumberland Md</u> DATE SIGNED <u>5-11-55</u> ADDRESS (Street, city, town, state) _____							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u> (State) _____	
24. REC'D BY REGISTRAR <u>May 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox - Cumberland, Md.</u> ADDRESS _____			

CERTIFICATE OF DEATH

REG. NO. 100

1. DEATH CERTIFICATE (NAME OF DECEASED)

2. DEATH CERTIFICATE (NAME OF DECEASED)

3. DEATH CERTIFICATE (NAME OF DECEASED)

4. DEATH CERTIFICATE (NAME OF DECEASED)

5. DEATH CERTIFICATE (NAME OF DECEASED)

6. DEATH CERTIFICATE (NAME OF DECEASED)

7. DEATH CERTIFICATE (NAME OF DECEASED)

8. DEATH CERTIFICATE (NAME OF DECEASED)

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30. DEATH CERTIFICATE (NAME OF DECEASED)

BUREAU V. S.

MAY 16 1955

RECEIVED

DEPARTMENT OF HEALTH

1. DEATH CERTIFICATE (NAME OF DECEASED)

2. DEATH CERTIFICATE (NAME OF DECEASED)

3. DEATH CERTIFICATE (NAME OF DECEASED)

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20. DEATH CERTIFICATE (NAME OF DECEASED)

21. DEATH CERTIFICATE (NAME OF DECEASED)

22. DEATH CERTIFICATE (NAME OF DECEASED)

23. DEATH CERTIFICATE (NAME OF DECEASED)

24. DEATH CERTIFICATE (NAME OF DECEASED)

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR R J WMS. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04240
4219 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		LENGTH OF STAY (in this place) 6 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 213 FULTON STREET			
3. NAME OF DECEASED: (First) JOHN (Middle) W (Last) NEFF				4. DATE (Month) (Day) (Year) OF DEATH: MAY 2, 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) MARRIED	8. DATE OF BIRTH: JAN. 4, 1869	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor		10B. KIND OF BUSINESS OR INDUSTRY: Mens Store		11. BIRTHPLACE (State or foreign country): VIRGINIA Weaverton		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James A. ,NEFF				14. MOTHER'S MAIDEN NAME: ,ANN CATHERINE, Hymes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-18-1046		17. INFORMANT & ADDRESS: Miss Margaret Neff, Cumberland, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 447X							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Arteriosclerotic							
DUE TO							
(B) Vascular disease (uremia)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-26-1955 to 5-2-1955 that I last saw the deceased alive on 5-2-1955 and that death occurred at 3:00P M. from the causes and on the date stated above.							
SIGNATURE W. J. Williams				ADDRESS M. D. Cumberland		DATE SIGNED 5-3-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 5 1955		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Cumberland Md.	
DATE REC'D BY LOCAL REGISTRAR May 5, 1955		REGISTRAR'S SIGNATURE Walter R. Tank, M.D.		24. FUNERAL DIRECTOR William H. Kight		ADDRESS Cumberland, Md.	

BUREAU V. S.

MAY 10 1955

RECEIVED

DR. LEY

4220

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
02 TOWN CUMBERLAND, MD.		5 DAYS		02 TOWN CUMBERLAND			
60 HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 408 PULASKI STREET			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) MARTHA A. NELSON				OF DEATH: MAY 8, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	OCTOBER 2, 1887	67 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY: OWN Home		11. BIRTHPLACE (State or foreign country): MT. SAVAGE, MD.	
13. FATHER'S NAME: JOHN P. WILLS				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage		
ANTECEDENT CAUSE (S) (B) Arteriosclerotic Hypertensive Disease		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/2, 1955, to 7/8, 1955, that I last saw the deceased alive on 7/7, 1955, and that death occurred at **1:35A.M.**, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL		DATE THEREOF: MAY 10, 1955	NAME OF CEMETERY OR CREMATORY: St. George Episcopal Cem.	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REGISTRAR: MAY 10, 1955		REGISTRAR'S SIGNATURE: Walter R. Hantz, M.D.	24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Md.	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 16 1955

BUREAU V. S.

4244
CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>Lifetime</u>		TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>84½ E. Main St.</u>				<u>84½ E. Main St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Rudolph Nickel</u>				<u>May 28th, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan. 4th, 1883</u>	<u>72 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Reporter</u>		<u>Newspaper</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Conrad Nickel</u>				<u>Margaret Hartman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>W.W.1</u>		<u>Alvin Nickel, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>157X</u>						—	
ANTECEDENT CAUSE (S)						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						7 mos	
(A) <u>Carcinoma head of pancreas</u>							
DUE TO							
(B) <u>with metastases to all</u>							
DUE TO							
(C) <u>abdominal viscera</u>						3 years.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Moderate arterio-sclerosis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>11-29-54</u>		<u>as under 18 above</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-15, 1954</u> , to <u>5-28, 1955</u> , that I last saw the deceased alive on <u>5-28, 1955</u> , and that death occurred at <u>3:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H.C. Diehl</u>		M. D. <u>Frostburg, Md.</u>		DATE SIGNED <u>5-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-31-1955</u>		<u>F'bg. Memorial Park</u>		<u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-31-55</u>		<u>Mr. Nancy A. De</u>		<u>Joseph R. Durst</u>		<u>Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

WASH. AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 3

JUN 2 1900

RECEIVED

INSTRUCTIONS
The law requires that the death certificate be executed within 24 hours after death.
The bottom copy may be retained by the hospital or attending physician.
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G182 6-9-55 and Items 8,9, film G183 6-29-55 et

4221

CERTIFICATE OF DEATH

04223

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ALLEGANY</u>	MARYLAND	STATE <u>W. VA.</u>	COUNTY <u>MINERAL</u>
CITY OR TOWN <u>CUMBERLAND</u>	LENGTH OF STAY (in this place) <u>19 days</u>	CITY OR TOWN <u>Piedmont</u>	(If rural give location) <u>85X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>		STREET ADDRESS <u>64 West Hampshire Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Dennis A Niland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-14-55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-27-55</u> 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if self-employed) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R. R. Co.</u>	9. AGE last birthday <u>67</u> 68 yrs.
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Niland</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Fallon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Chart</u>	
17. INFORMANT & ADDRESS <u>Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
152X IMMEDIATE CAUSE (A) <u>generalized peritonitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>(involved the ileum of the small bowel and the transverse colon)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>5-4-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>quaternary carcinoma involving ileum and transverse colon</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. el work) (Not while el work)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-25, 1955, to 5-14, 1955, that I last saw the deceased alive on 5-14, 1955, and that death occurred at 10:00 AM, from the causes and on the date stated above.			
SIGNATURE <u>J. J. Johnson</u>		ADDRESS (Street, city, town, state) <u>Cumberland, Md</u>	
DATE SIGNED <u>5-14-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>May 17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peter's & Paul's</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md</u>	
24. REC'D BY REGISTRAR <u>May 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.A.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold Fredrick</u>		ADDRESS <u>Piedmont</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

MAY 17 1965

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4222

CERTIFICATE OF DEATH

04224

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland, Md.</u>		8 Days.		02 TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
62 <u>Sacred Heart Decatur St.</u>				267 Williams St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
Robert Floyd Norris				May 11 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	1-22-1888	67 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Supervisor, Art. Silk Mill					Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Not Known				Nettie Norris Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
2 No		217-10-5783		Cumberland, Md. Wife, Gladys Norris, 267 Williams St.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
581.0 IMMEDIATE CAUSE (A) <u>hepatic coma</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cirrhosis of the liver</u>						4 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-2-</u> , 19 <u>55</u> , to <u>5-11-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-11-</u> , 19 <u>55</u> , and that death occurred at <u>4:58</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>W. Norris</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				M.D. <u>5/11/55</u>		<u>5-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5/15/55		Hillcrest Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
May 13, 1955		Winter R. Tantz, M.D.		H. Lee Silcox -		Cumberland, Md.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

BUREAU V. S.

MAY 17 1935

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 104225
4223 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Allegany	MARYLAND	STATE Maryland	COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	LENGTH OF STAY (in this place) 4/29/53	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary		STREET ADDRESS (If rural give location) X	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Nora	(Middle)	(Last) O'Conner	OF DEATH: May 24, 1955
(Type or Print)			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: 12/31/1869
			9. AGE last birthday: 85 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Ryhan Shaffer		14. MOTHER'S MAIDEN NAME: Susan Dean	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, or unk.) (if Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Allegany County Infirmary Records			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary Hypostasis			72 hrs
ANTECEDENT CAUSE (S) (B) Chronic Myocarditis			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Cerebral Hemorrhage			?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Arteriosclerosis			?
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 31, 1953 to May 24, 1955 that I last saw the deceased alive on May 24, 1955 , and that death occurred at 7:00 P. M. from the causes and on the date stated above.			
SIGNATURE J. R. Durst		DATE SIGNED 5-25-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1955	
NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery, Mt. Savage, Maryland		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR May 26, 1955		REGISTRAR'S SIGNATURE Walter R. Frank, M.D.	
24. FUNERAL DIRECTOR J. R. Durst		ADDRESS Frostburg, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUN 2 1955

RECEIVED

4252

CERTIFICATE OF DEATH

Reg. Dist. No. / 0

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Mt. Savage</u>				OR TOWN <u>Mt. Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				Church Hill			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
Rosalie		V.		O'Rourke			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Married		Aug. 26th, 1887	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
67 yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Housework		Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Francis B. McDermitt				Catherine O'Brien			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
9				None		Patrick O'Rourke, Mt. Savage, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
174X IMMEDIATE CAUSE						2 years	
(A) DUE TO Carcinoma Uterus & Vagina							
ANTECEDENT CAUSE (S):						4 years	
(B) DUE TO Coronary Sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						4 years	
(C) DUE TO Vascular Hypertension							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June, 1955, to May, 1955, that I last saw the deceased alive on May 8, 1955, and that death occurred at 5:10 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
William E. Mowley		Mt. Savage Md.		May 9 th 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 11th, 55		St. Patrick's Cemetery		Mt. Savage, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 23, 1955		Therese McDermitt		Joseph R. Durst		Frostburg, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955

BUREAU V. S.

MAY 24 1955

RECEIVED

4224

CERTIFICATE OF DEATH

04227

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>112 Spruce St.</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>112 Spruce St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>Iola</u> (Last) <u>Page</u>				(Month) <u>May</u> (Day) <u>9</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 3, 1909</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic in home of R. W. Ballin, M.D.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A Page</u>				14. MOTHER'S MAIDEN NAME <u>Iola Males</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-1518</u>		17. INFORMANT & ADDRESS <u>Mrs Iola Page Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 1/2 years</u>	
171X IMMEDIATE CAUSE (A) <u>Cancer of uterine cervix</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1</u> <u>May 53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adeno carcinoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-25</u> , 19 <u>53</u> , to <u>5-9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-9</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Reeta W. Ballin</u>		M.D. <u>Cumberland, Md.</u>		DATE SIGNED <u>5-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 13 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>May 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. [unclear] M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein Inc. Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MAY 17 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Q4228

4225. CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>02</u> TOWN <u>Cumberland</u>		<u>15 Yrs</u>		<u>02</u> TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u> <u>II4 Spruce St.</u>				<u>1</u> <u>II4 Spruce St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Pearl</u> (Middle) <u>Melville</u> (Last) <u>Paige</u>				(Month) <u>May</u> (Day) <u>II</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>August 13, 1913</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own Home</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Lewis</u>				<u>Bessie Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4</u> <u>No</u>				<u>Forest Paige Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>157X</u> IMMEDIATE CAUSE (A) <u>Cancer of the pancreas</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>1 4-9-55</u>		<u>Cancer of pancreas, per admet</u>				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>1-2-</u>, 19<u>55</u>, to <u>5-11-</u>, 19<u>55</u>, that I last saw the deceased alive on <u>5-11-</u>, 19<u>55</u>, and that death occurred at <u>1:48</u> M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>L. K. Kins</u>		<u>May 14 1955</u>		<u>Saint Peter & Paul</u>		<u>Cumberland Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 14 1955</u>		<u>Saint Peter & Paul</u>		<u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 13, 1955</u>		<u>Winter R. Frantz, M.D.</u>		<u>Louis Stein Inc.</u>		<u>CUMBERLAND MARYLAND</u>	

RECEIVED

1. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

2. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

3. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

4. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

5. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

6. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

7. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

8. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

9. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

10. This is to certify that the following is a true and correct copy of the original as filed in the files of the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
John Doe		Male		45		White		May 1, 1955		Home		Heart Disease		Natural		J. Doe, M.D.		A. Smith	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. SEX		14. RACE		15. DATE OF DEATH		16. PLACE OF DEATH		17. CAUSE OF DEATH		18. MANNER OF DEATH		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	
Maryland		May 1, 1955		Male		White		May 1, 1955		Home		Heart Disease		Natural		J. Doe, M.D.		A. Smith	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. SEX		14. RACE		15. DATE OF DEATH		16. PLACE OF DEATH		17. CAUSE OF DEATH		18. MANNER OF DEATH		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	
Maryland		May 1, 1955		Male		White		May 1, 1955		Home		Heart Disease		Natural		J. Doe, M.D.		A. Smith	

RECEIVED

MAY 17 1955

BUREAU V. 1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4226

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04229

1. PLACE OF DEATH <i>Allegany Co Infirmary</i>				USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Allegany</i>		MARYLAND		STATE <i>Pa</i>		COUNTY <i>Allegany</i>	
CITY (If outside corporate limits, write name and give nearest town) <i>02</i> TOWN <i>Cumberland</i>		LENGTH OF STAY (in this place) <i>38 yrs</i>		CITY (If outside corporate limits, write name and give nearest town) <i>02</i> OR TOWN <i>Cumberland</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>91</i> <i>Allegany County Infirmary</i>				STREET ADDRESS (If rural give location) <i>1</i> <i>12 Thompson Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>CATHERINE MARGARET PETENBRINK</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>May 15 1955</i>			
5. SEX <i>2</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed June 5th 1891</i>	8. DATE OF BIRTH <i>June 5th 1891</i>	9. AGE last birthday <i>63</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Peter Paul Michaels</i>				14. MOTHER'S MAIDEN NAME: <i>Wilhelmina Martens</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>4-no</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS: <i>Records at Infirmary</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i>						?	
ANTECEDENT CAUSE (B) <i>Chronic Hepatitis</i>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>General Arteriosclerosis</i>						?	
(C) <i>Paralysis Agitans</i>						6 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 2, 1952</i> to <i>May 15 55</i> , that I last saw the deceased alive on <i>May 14, 1955</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>James E. DeLoan</i>		M.D.		ADDRESS <i>47 Grecco St</i>		DATE SIGNED <i>5-16-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 18 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Porter Cemetery</i>		LOCATION (City, town, or county) (State) <i>Eckhart, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 17, 1955</i>		REGISTRAR'S SIGNATURE <i>Walter R. Tandy, M.D.</i>		24. FUNERAL DIRECTOR <i>William H. Kight</i>		ADDRESS <i>Cumberland, Md.</i>	

BUREAU V. S.

MAY 24 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04230

4227 **CERTIFICATE OF DEATH**Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>02 CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>9 Hrs-15 Min</u>		CITY OR TOWN <u>Near Cumberland, rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>		STREET ADDRESS <u>R. F. D. #5</u>		(If rural give location)		1	
3. NAME OF DECEASED (Type or Print) <u>William Granville Raines</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>23</u> (Year) <u>55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12-30-79</u>	
9. AGE last birthday <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed Pendleton Co, West Va.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Raines-deceased</u>				14. MOTHER'S MAIDEN NAME <u>Ella Sites</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-8397</u>		17. INFORMANT & ADDRESS <u>Hospital Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
561.3 IMMEDIATE CAUSE (A) <u>congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>repair of strangulated umbilical hernia</u>				<u>3 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis</u>				<u>2 years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5-23-55</u>				19b. MAJOR FINDINGS OF OPERATION <u>strangulated umbilical hernia</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) <u>M. 5-23-55</u>				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>5-23-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-23-</u> , 19 <u>55</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Raines</u>				DATE SIGNED <u>5-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Raines Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pedleton County, West Va.</u>	
24. REC'D BY REGISTRAR <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Hager</u>		ADDRESS <u>Cumberland Md</u>	

Within corporate limit.

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4228

04231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	TOWN
<u>02</u> TOWN <u>Cumberland</u>	<u>50 yrs.</u>	TOWN <u>Cumberland</u>	<u>02</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>501 Linden St.</u>		STREET ADDRESS (If rural, give location) <u>501 Linden St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Clara</u>	(Middle) <u>G.</u>	(Last) <u>Reith</u>	(Month) <u>May</u> (Day) <u>7</u> (Year) <u>1955</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Sept 14-1884</u>
9. AGE last birthday: <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frederick W. Reith</u>		14. MOTHER'S MAIDEN NAME: <u>Augusta Finkledey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>214-05-4534</u>	
17. INFORMANT & ADDRESS: <u>Sister Mrs. Dora Birch, Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO			<u>sudden</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u> DUE TO			<u>gradual</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Myocarditis</u>			<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>0</u>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 8-1955</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>May 11 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cumberland Md</u>
DATE REC'D BY LOCAL REG. <u>May 10, 1955</u>	REGISTRAR'S SIGNATURE <u>Walter R. Parry, M.D.</u>	24. FUNERAL DIRECTOR <u>William H. Kight,</u>	ADDRESS <u>Cumberland Md.</u>

BUREAU V. S.

MAY 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04232

4253

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Eckhart</u>		<u>5 Yrs.</u>		TOWN <u>Eckhart</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>James</u> (Middle) <u>R.</u> (Last) <u>Ross</u>				5 7 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>M</u>	<u>White</u>	<u>Single</u>	<u>10-26-1873</u>	<u>81 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Miner</u>		<u>Coal Mines</u>		<u>Lonaconing, Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Ross</u>				<u>Janet Stevenson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>None</u>		<u>Eckhart, Md.</u> <u>Mrs. Florence Lewis, Nièce</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
241X IMMEDIATE CAUSE (A)				<u>Right Heart failure</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Cor Pulmonale</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Chronic Asthmatic Bronchitis</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>3 days.</u>			
				<u>± 15 years</u>			
				<u>± 30 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/1/53</u> , 19 <u>51</u> , to <u>5/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Frank T. Harvat</u>				<u>M.D. 26 Mechanic St. Frostburg, Md.</u>		<u>5/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-9-1955</u>		<u>Oak Hill Cemetery</u>		<u>Lonaconing Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5-11-55</u>		<u>Wm. T. Harvey</u>		<u>Reuben H. Mattingly</u>		<u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

RECORDED

1. Name of deceased: [illegible]
 2. Sex: [illegible]
 3. Age: [illegible]
 4. Date of birth: [illegible]
 5. Place of birth: [illegible]
 6. Date of death: [illegible]
 7. Place of death: [illegible]
 8. Cause of death: [illegible]
 9. Signature of physician: [illegible]
 10. Signature of registrar: [illegible]

BUREAU V. 3

MAY 17 1955

RECEIVED

5-11-55

INSTRUCTIONS
1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4229

CERTIFICATE OF DEATH

04233

DR. W.F. WILLIAMS

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		TOWN <u>02</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u>		LENGTH OF STAY (in this place) <u>36 DAYS</u>		STREET ADDRESS <u>508 WASHINGTON STREET</u>		(If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60 MEMORIAL HOSPITAL</u>							
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>SCHWARZENBACH</u> (Last) <u>SCHWARZENBACH</u>				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>20</u> (Year) <u>19 55</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>FEBRUARY 12, 1873</u>	
						9. AGE last birthday <u>82</u> yrs. IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u> IF UNDER 24 HRS. (Hours) <u></u> (Min.) <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE SCHWARZENBACH</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET WIEGMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>MEMORIAL HOSPITAL - CUMBERLAND, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>442x Hypertensive Arterio</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Since</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Sclerotic Cardio Vascular</u>				<u>5 if</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Renal disease.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>July 6, 1954, 11:35 P.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 6, 1954, to July 20, 1955, that I last saw the deceased alive on July 20, 1955, and that death occurred at 11:35 P.M. from the causes and on the date stated above.							
SIGNATURE <u>W.F. Williams</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland</u> DATE SIGNED <u>5-22-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>May 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Dantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

DR. W. F. WILLIAMS

Reg. Dist. No.

A. MARYLAND DEPARTMENT OF HEALTH

DATE OF DEATH

ALLEGED

30 DAYS

DECEASED

HOSPITAL

100 WASHINGTON STREET

COMPLAINT

DEATH

ADMITTED

WHITE

MALE

RESIDENT

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. S.

MAY 24 1955

RECEIVED

11:30

DECEASED

DECEASED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04234

4230

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>30</u> years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>511 Forester Ave.</u>				STREET ADDRESS (If rural give location) <u>511 Forester Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>John</u> <u>Kerr</u> <u>Sears</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 24, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>McKeesport, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stingley Sears</u>				14. MOTHER'S MAIDEN NAME <u>Leah Copp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-8527</u>		17. INFORMANT & ADDRESS <u>Ave.</u> <u>Mrs. Regina Sears-511 Forester,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>443X</u> <u>Chronic Hypertension Arterio</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Since</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerotic C. V. Disease</u>						<u>July '53</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-17-55</u> , to <u>5-17-55</u> , that I last saw the deceased alive on <u>5-17-55</u> , and that death occurred at <u>7:14</u> M., from the causes and on the date stated above.							
SIGNATURE <u>M. J. Williams</u> M.D. <u>Cumberland</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>5-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>May 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Tandy, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

4330 CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. Name of deceased: *John*

2. Sex: *Male*

3. Age: *40*

4. Date of death: *May 24, 1955*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Date of burial: *May 26, 1955*

8. Name of funeral home: *John Doe*

9. Name of physician: *John Doe*

10. Name of medical examiner: *John Doe*

BUREAU V. 2

MAY 24 1955

RECEIVED

RECEIVED

MAY 24 1955

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ALLEGANY		MARYLAND		STATE Pennsylvania COUNTY Bedford			
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 2 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HYNDMAN, rural		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) ROUTE #1			
3. NAME OF DECEASED: (First) (Middle) (Last) BABY GIRL SHROYER				4. DATE (Month) (Day) (Year) OF DEATH: MAM 6 191955			
5. SEX: FEMALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE		8. DATE OF BIRTH: MAY 4, 1955	
9. AGE last birthday: None		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): CUMBERLAND MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME: ROY E SHROYER			
14. MOTHER'S MAIDEN NAME: RUTH IRENE WILLISON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): # No			
16. SOCIAL SECURITY NO.: None				17. INFORMANT & ADDRESS: Roy E. Shroyer, Hyndman, Pa RD 1			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Respiratory Failure							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Prematurity							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4 May 1955 , to 5 May 1955 , that I last saw the deceased alive on 5 May 1955 , and that death occurred at 6:40AM , from the causes and on the date stated above.							
SIGNATURE Dr. Ransom		M. D. 63 Grand St.		DATE SIGNED 6 May 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 7, 1955		NAME OF CEMETERY OR CREMATORY Comps Cemetery		LOCATION (City, town, or county) (State) Hyndman, Somerset Co, Pa	
DATE REC'D BY LOCAL REGISTRAR May 7, 1955		REGISTRAR'S SIGNATURE Walter R. Frank, M.D.		24. FUNERAL DIRECTOR Harvey H. Leigler		ADDRESS Hyndman, Pa.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1955

BUREAU V. S.

4232

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		HYNDMAN, rural	
120 TOWN CUMBERLAND		14 HRS 37 M N.		75X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
60 MEMORIAL HOSPITAL				ROUTE #1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
BABY GIRL SHROYER - Triplet #3				MAY 4 19 55			
5. SEX: FEMALE		6. COLOR OR WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE		8. DATE OF BIRTH: MAY 4, 1955	
				9. AGE last birthday yrs.		10. IF UNDER 1 YEAR Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None				10B. KIND OF BUSINESS OR INDUSTRY:			
				11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND			
13. FATHER'S NAME: ROY E SHROYER				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME: RUTH IRENE WILLISON							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) 47th				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS: Roy E Shroyer, Hyndman Park							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
774X IMMEDIATE CAUSE (A) Respiratory Failure							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Prematurity							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4 May, 1955, to 4 May, 1955, that I last saw the deceased alive on 4 May, 1955, and that death occurred at 6:22P M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
Leland Ransom				63 Greene ST.		5 May 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 7 1955		Comps Cemetery		Hyndman, Somerset Co, Pa	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 7, 1955		Walter R. Wang, M.D.		Harvey A. Keegler		Hyndman, Pa	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1955
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4254

CERTIFICATE OF DEATH

04237

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Lonaconing		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 State Street				STREET ADDRESS (If rural give location) State Street			
3. NAME OF DECEASED (Type or Print) Mary Elizabeth Sloan				4. DATE OF DEATH (Month) May , (Day) 23 , (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept, 30, 1879	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Wom Home		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Donald				14. MOTHER'S MAIDEN NAME Fredreka Cutter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Melvin Sloan, Lonaconing, MD.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 2 mo.			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease				7 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19 52, to 23 May 19 55 that I last saw the deceased alive on 22 May 19 55, and that death occurred at 12 30 P.M. from the causes and on the date stated above.							
SIGNATURE George Richard		M.D. Lonaconing Md.		ADDRESS (Street, city, town, state) Lonaconing, MD.		DATE SIGNED 5-23-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF May 25, 1955		NAME OF CEMETERY OR CREMATORY Old Coney Cemetery		LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. REC'D BY REGISTRAR DATE May 25 1955		REGISTRAR'S SIGNATURE Janette M. Boal		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	

RECEIVED
MAY 27 1955
BUREAU V. 1

MAY 27 1955

1. With the corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04238

4233

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53-10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY OR TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY OR TOWN <u>FROSTBURG</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>		STREET ADDRESS <u>102 BRADDOCK STREET</u>					
3. NAME OF DECEASED (Type or Print) <u>Dillon</u> (First) <u>HERBERT</u> (Middle) <u>SMITH</u> (Last)				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-29-10</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad B&O.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Catherine King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>211-05-6218</u>		17. INFORMANT & ADDRESS <u>CHART</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5/9/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>3:45</u> P. <u>46</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/6/55</u> , 19 <u>55</u> , to <u>5/7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6/55</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Herbert H. Brungs</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>5/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cem.</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>May 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jacob Hafer, Frostburg, Md.</u>			

10300

CERTIFICATE OF DEATH

10300

Page 1 of 1

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. MARITAL STATUS

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEAREST RELATIVE

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF CLERK

23. SIGNATURE OF Scribe

24. SIGNATURE OF Notary Public

25. SIGNATURE OF Registrar

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MARYLAND STATE DEPARTMENT OF HEALTH

04239

2411 N. Charles Street, Baltimore

4245

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY <u>allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>alleg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>		STREET ADDRESS (If rural, give location) <u>Miners Hospital</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Paula</u>	(Middle) <u>Jean</u>	(Last) <u>Smith</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>baby</u>	8. DATE OF BIRTH <u>5-7-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baby</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. <u>5</u> Months <u>7</u> Days <u>114</u>
13. FATHER'S NAME <u>Paul George Smith</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>9</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Paul George Smith, Frostburg, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Alice B. Combs.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
776X Immediate cause (a) <u>Premature Birth (4 3/4 mos)</u>				<u>114 minute</u>	
Antecedent cause(s)					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>5-8-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>—</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>5-7</u> , 19 <u>55</u> , to <u>5-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-7</u> , 19 <u>55</u> , and that death occurred at <u>8:20¹⁴ P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>H.C. Diehl, M.D.</u>		ADDRESS <u>Frostburg, Md.</u>		DATE SIGNED <u>5/8/55</u>	
23. BURIAL, CREMATION REMOVAL <u>Burial</u>		DATE <u>5-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>	
LOCATION (City, town, or county) <u>allegany</u>		(State) <u>Md.</u>		24. FUNERAL DIRECTOR <u>J. K. Dwyer</u>	
DATE REC'D BY LOCAL REG. <u>5-8-55</u>		REGISTER'S SIGNATURE <u>Wm. Harvey V. Roe</u>		ADDRESS <u>Frostburg, Md.</u>	

2055301201

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 13 1955
BUREAU V. S.

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4246 **CERTIFICATE OF DEATH**

04240

9

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Md.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 22 Frostburg		LENGTH OF STAY (in this place) 7 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital				STREET ADDRESS (If rural give location) 33 Washington Street			
3. NAME OF DECEASED (Type or Print) William Lenard Stotler				4. DATE OF DEATH May, 21 st. 19 55			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Oct, 9th. 1866	
				9. AGE last birthday 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Burlington, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Stotler				14. MOTHER'S MAIDEN NAME Susan -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Ruth Martin (Daughter)	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION Frostburg, Md.			
590X IMMEDIATE CAUSE (A) Acute Nephritis				INTERVAL BETWEEN ONSET AND DEATH 2 wks			
ANTECEDENT CAUSE(S) DUE TO (B) Prostatic Hypertrophy							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 4, 19 55 to May 21, 19 55 , that I last saw the deceased alive on May 21, 19 55 and that death occurred at 8:45 PM from the causes and on the date stated above.							
SIGNATURE W. J. Lane MD		M.D. Frostburg Md		ADDRESS (Street, city, town, state) May 21, 19 55		DATE SIGNED May 21, 19 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May, 24. 1955		NAME OF CEMETERY OR CREMATORY Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Md.	
24. REC'D BY REGISTRAR DATE 5-26-55		REGISTRAR'S SIGNATURE Wm. Harvey N. Rose		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.			

CERTIFICATE OF DEATH

PLACE OF DEATH		MARYLAND	
COUNTY		Baltimore	
CITY		Baltimore	
STREET		33 Washington Street	
APARTMENT			
DECEASED		Male	
NAME		William James	
AGE		7 weeks	
SEX		Male	
MARRIAGE		Married	
DATE OF BIRTH		1938	
PLACE OF BIRTH		Baltimore, Md.	
OCCUPATION		Student	
CAUSE OF DEATH		Sudden	
DATE OF DEATH		1938	
SIGNATURE OF DECEASED			
SIGNATURE OF WITNESSES			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF CLERK			

*Wm. James
1938*

BUREAU V. S.

MAY 31 1938

RECEIVED

George Washington, Baltimore, Md.

NOTIFICATION

12

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4255

CERTIFICATE OF DEATH

04241

Reg. Dist. No. 8

Item 8, Film 182 6-8-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) Lonaconing		LENGTH OF STAY (in this place) 64		CITY (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Detmold Street				STREET ADDRESS (If rural give location) Detmold Street			
3. NAME OF DECEASED (Type or Print) Racheal Ternent				4. DATE OF DEATH (Month) (Day) (Year) May 11, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug 26, 1890	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James P. Darnley				14. MOTHER'S MAIDEN NAME Margaret Metz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS William Ternent (SON)			
18. MEDICAL CERTIFICATION				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) Coronary Occlusion				10 hours			
ANTECEDENT CAUSE(S) DUE TO (B) Congestive Heart Failure				1 year			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis Generalized				3 yrs			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus				10 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 11, 1952 to May 11, 1955 , that I last saw the deceased alive on May 11, 1955 , and that death occurred at 6:54 AM , from the causes and on the date stated above.							
SIGNATURE George Eichhorn				DATE SIGNED 5/15/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF May 13, 1955		NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		LOCATION (City, town, or county) (State) Moscow, MD.	
24. REC'D BY REGISTRAR 5-13-55		REGISTRAR'S SIGNATURE Joanette M Boal		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.			

CERTIFICATE OF DEATH

4555

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Reg. Ord. No.

1. USUAL RESIDENCE (RIGHT OF US CITIZEN)

2. PLACE OF DEATH

3. SEX ☒ Male ☐ Female

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SEX

14. RACE

15. OCCUPATION

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF BIRTH

19. PLACE OF DEATH

20. PLACE OF DEATH

21. PLACE OF DEATH

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESSES

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27. SIGNATURE OF WITNESSES

BUREAU V. S.

MAY 18 1955

RECEIVED

MAY 18 1955

George Richmond, Annapolis, MD

George Richmond, Annapolis, MD

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4256

CERTIFICATE OF DEATH

04242

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Eckhart</u>		<u>34 yrs.</u>		TOWN <u>Eckhart</u>		Box <u>58</u> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
13. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>Elizabeth Clementine</u>		<u>Ward</u>		<u>5</u> <u>11</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>White</u>	<u>Widowed</u>	<u>11 - 18 - 1882</u>	<u>72</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Lonaconing, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Duckworth</u>				<u>Clementine Pearce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<input checked="" type="checkbox"/> No		<u>None</u>		<u>Daughter</u>			
				<u>Mrs. Richard Witte, Eckhart, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
434.3 IMMEDIATE CAUSE (A) <u>acute cardiac dilatation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic myocarditis</u>						<u>2 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>5-11</u>		<u>Chronic myocarditis</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>X</u>			
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>53</u> , to <u>5-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>H.C. Diehl</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>5/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-14-55</u>		<u>Frostburg Memorial Park Frostburg</u>		<u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>5-14-55</u>		<u>Mrs. Nancy H. Rose</u>		<u>B.H. Montesant</u>		<u>23 East Main Frostburg, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04243

4247

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Frostburg</u>		<u>2 days</u>		TOWN <u>Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>269 Welsh Hill</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Ware</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>8</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 23, 1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>		11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ware</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Frostburg, Md.</u>			
				<u>Mrs. John Broadbeck, 377 Welsh Hill</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				Sexual <u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Insufficiency</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 6, 1955</u> to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 7, 1955</u> , and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. M. C. Lane</u>		DATE THEREOF <u>5-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>FROSTBURG MEMORIAL PARK</u>		LOCATION (City, town, or county) <u>FROSTBURG, MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		REGISTRAR'S SIGNATURE <u>Wm. Percy N. R...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>...</u>		DATE SIGNED <u>5-10-55</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>E. MAIN, FROSTBURG, MD.</u>			
DATE <u>5-11-55</u>							

DECLASSIFIED

MAY 17 1955

RECEIVED

BUREAU V. S.

4234 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		1 DAY		TOWN LA VALE, MD.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL MEMORIAL AVE.				/			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARIE		(Middle) MYERS		(Last) WELSH			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOW	NOV. 24, 1880	74 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Home		PENNSYLVANIA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RANDOLPH MYERS				CATHERINE RIST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Memorial Hosp Cumberland, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						26 hours	
442X IMMEDIATE CAUSE (A) Cerebro-Vascular Accident (Hemorrhage)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						?	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October 28, 1953, to May 31, 1955, that I last saw the deceased alive on May 31, 1955, and that death occurred at 9:25 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Charles Jacobson, M.D.				50 Pershing Street, Cumberland, Md.		June 1, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Buried		6-4-55		Cavalry Cem.		altoona, Pa.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 1, 1955		Winter R. Long, M.D.		Charles L. George-Cumbl, Md.			

INSTRUCTIONS

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2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

4284 CERTIFICATE OF DEATH

Reg. No. 125

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF DEPUTY CHIEF CLERK

24. SIGNATURE OF RECORDS CLERK

25. SIGNATURE OF CLERK OF THE COURT

26. SIGNATURE OF CLERK OF THE DISTRICT COURT

27. SIGNATURE OF CLERK OF THE COUNTY COURT

28. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT

29. SIGNATURE OF CLERK OF THE SUPREME COURT

30. SIGNATURE OF CLERK OF THE HOUSE OF REPRESENTATIVES

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF DEPUTY CHIEF CLERK

24. SIGNATURE OF RECORDS CLERK

25. SIGNATURE OF CLERK OF THE COURT

26. SIGNATURE OF CLERK OF THE DISTRICT COURT

27. SIGNATURE OF CLERK OF THE COUNTY COURT

28. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT

29. SIGNATURE OF CLERK OF THE SUPREME COURT

30. SIGNATURE OF CLERK OF THE HOUSE OF REPRESENTATIVES

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE LAWS OF THE STATE OF MARYLAND.

BUREAU V. S.

JUN 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Cumberland</u>		<u>15 yrs.</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>605 Shriver Ave.</u>				STREET ADDRESS (If rural, give location) <u>605 Shriver Ave.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Miller</u>		(Middle) <u>Tennant</u>		(Last) <u>Williams</u>		(Month) <u>May</u> (Day) <u>8</u> (Year) <u>19 55</u>	
(Type or Print)							
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>March 17-1893</u>	
9. AGE last birthday: <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Nikep (Pekin) Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert Tennant</u>				14. MOTHER'S MAIDEN NAME: <u>Jeanette Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>(son) Wm. B. Williams, Cumberland, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p>974x Immediate cause (a) <u>Asphyxia</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>Strangulation by hanging.</u> DUE TO</p> <p>giving rise to the above cause</p> <p>stating underlying cause last (c)</p>						<p>about 5 minutes...</p>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>							
19a. DATE OF OPERATION: <u>May 8-1955</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Attic at home.</u>		21c. (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u>			
21d. TIME (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1955</u> (Hour) <u>A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hung herself in the attic at her home.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 8-1955</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) <u>Moscow, MD.</u> (State)	
DATE RECD BY LOCAL REG <u>May 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Winters R. Toney, M.D.</u>		24. FUNERAL DIRECTOR <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

BUREAU V. S.

MAY 16 1975

RECEIVED

George G. G. G.

Letter Will

George G. G.

George G. G.

4236

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE PENNSYLVANIA		COUNTY Bedford	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		17 DAYS		TOWN BREEZEWOOD		75x3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
JERRY BABY BOYON VICTOR WILT - TWIN #1				MAY 16 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
MALE	WHITE	SINGLE	APRIL 29, 1955		17		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				CUMBERLAND, MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
VICTOR D. WILT				NORMA JEAN WINTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
4 NO		NONE		Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
776X IMMEDIATE CAUSE (A)				Premature twin		17 days	
ANTECEDENT CAUSE(S) DUE TO				(Repeat section)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-29, 1955, to 5-16, 1955, that I last saw the deceased alive on 5-16, 1955, and that death occurred at 6:46 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
W. R. Hodges				Cumberland, Md.		5-11-55	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		5/17/55		BREEZEWOOD LUTHERAN		E. PROV. TWP BEDFORD CO PA.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
May 17, 1955		Winter R. Stantz, M.D.		Lyford V. Connor, Everett, Pa.			

2145272393

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. DURATION OF ILLNESS

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. PLACE OF BIRTH

14. DATE OF BIRTH

15. SEX

16. AGE

17. OCCUPATION

18. PLACE OF BIRTH

19. DATE OF BIRTH

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF REGISTRAR

BUREAU V. 1

MAY 24 1955

RECEIVED

EXOTICISM

THE NATIONAL BUREAU OF VITAL STATISTICS OF THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
 OFFICE OF VITAL STATISTICS
 1200 K STREET, N.W.
 WASHINGTON, D.C. 20004